

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02974 CERTIFICATE OF DEATH 02955									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			c. LENGTH OF STAY IN ID		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>TO PENINSULA GENERAL HOSPITAL</u>					d. STREET ADDRESS <u>427 Elizabeth St</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY ELIZABETH AGNEW</u>			First Middle Last		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>4</u> Year <u>1966</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 19/1886</u>		9. AGE (In years last birthday) <u>79</u> yrs. <u>11</u> months <u>15</u> days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Snow Hill Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Harry Round</u>					14. MOTHER'S MAIDEN NAME <u>Emma Richardson</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>150-10-7772</u>		17. INFORMANT Address <u>Mrs. Elizabeth Marie Seabrease (Daughter)</u> <u>427 Elizabeth St Salisbury, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Stroke</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 mths</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1/18</u> , 19 <u>66</u> to <u>2-4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-4</u> , 19 <u>66</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>W B Smith</u>					22b. DATE SIGNED <u>2-4-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. William B. Smith</u>		
22d. ADDRESS <u>Salisbury, Maryland</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 6/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>			23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>		
24. FUNERAL DIRECTORY ADDRESS <u>HOLLOWAY & COMPANY SALISBURY, MARYLAND</u>					25a. REC'D BY REGISTRAR <u>Feb 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

05052

05052

Wilmington

Wilmington

Wilmington

Wilmington DE

WILMINGTON

Dec. 12/1966 12 12

How Hill Wilmington

How work at home

How Hill Wilmington

How Hill Wilmington

How Hill Wilmington DE

120-10-7772

120-10-7772

W/A

Dr. William E. Smith

Rep. 6/1966 How Hill Wilmington

How Hill Wilmington, Maryland

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02975 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02956

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural) c. LENGTH OF STAY IN ID 3-Months d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naylor Mill Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards d. STREET ADDRESS U.S. Route #50 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WALTER THOMAS ALEXANDER		4. DATE OF DEATH FEBRUARY 21 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20/1902
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 1 Hours Min. 	
11. BIRTHPLACE (State or foreign country) Wicomico Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME J. Earl Alexander		14. MOTHER'S MAIDEN NAME Lavinia C. Bailey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Wallace Cooper (Sister)		Address Ocean City Road Willards, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Crown Aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Earl L. Royer		22. DATE SIGNED Feb. 21/1966	
EXAMINER'S NAME (Type) 409 Camden Ave, Salisbury, Md		Address (Street, city, town, or county) 	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 23/1966	23c. NAME OF CEMETERY OR CREMATORY Smith-Mills Cem.	23d. LOCATION (City, town or county) (State) Sussex Co., Delaware
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	
25a. REC'D BY REGISTRAR FEB 23 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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10500

Wisconsin

Michigan

Michigan

Michigan

Salisbury (Hwy) 3-Months

U.S. Routes

Walter Hill Road

February 21 66

WALTER THOMAS ALEXANDER

Sept. 10/1966

Male White

Salisbury Driver-Engineer (Oil Co.) Wisconsin Co., Weymouth U.S.A.

James C. Bailey

J. R. Alexander

Mr. James Cooper (Salisbury) Boston City
Local Valuation, Weymouth

No

James C. Bailey

MA

X

X

Feb. 21/66

X

609 Gordon Ave., Salisbury, MA
Dr. Earl I. Brown

Corpus Co., Delaware

Salisbury Feb. 23/1966

WILSON & COMPANY, SALISBURY, MARYLAND

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02976

02958

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>RFD 2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BETSEY TAYLOR BAKER</u>				4. DATE OF DEATH Month Day Year <u>FEBRUARY 23 19 66</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 14, 1916</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>EAST HAMPTON N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES C. TAYLOR</u>				14. MOTHER'S MAIDEN NAME <u>BETSEY PAYNE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>MR. CRAUS B. BAKER</u>		Address <u>R.F.D. 2 BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Carcinoma of Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>15 minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bilateral cystosarcoma</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7-22</u> , 19 <u>66</u> to <u>7-23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7-23</u> , 19 <u>66</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>H. F. Briele</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-23-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. F. Briele</u>		22d. ADDRESS <u>Medical Center Salisbury, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7-26-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SUNSET MEMORIAL</u>		23d. LOCATION (City, town or county) (State) <u>BERLIN MD</u>	
24. FUNERAL DIRECTOR <u>Anna D. Burdette Berlin Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02977

02959

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 201 Holland Ave		d. STREET ADDRESS 201 Holland Ave.	
3. NAME OF DECEASED (Type or print) First EDWARD Middle FRANCIS Last BOOTH		4. DATE OF DEATH Month FEBRUARY Day 13 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 14/1895
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 0 Days 29	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Barber (Barber shop owner)		10b. KIND OF BUSINESS OR INDUSTRY Salisbury, Maryland	
11. BIRTHPLACE (County & State, or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Frank J. Booth		14. MOTHER'S MAIDEN NAME Annie Hastings	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-32-0562A	
17. INFORMANT Mrs. Carrie M. Booth (Wife)		Address 201 Holland Ave., Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lung 1634 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Chronic Hypertensive C.V. Disease (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombophlebitis of Left Leg.		INTERVAL BETWEEN ONSET AND DEATH 6 months 3 years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 9, 1965 to Feb. 13, 1966 , that (I) (we) last saw the deceased alive on Feb. 13, 1966 , and that death occurred at 8:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. G. Herbert Sembly		22b. DATE SIGNED Feb. 14/1966	
22c. PHYSICIAN'S NAME (Type) Dr. G. Herbert Sembly		22d. ADDRESS E. Church St. Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 16/1966	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR FEB 15 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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Wisconsin

Wisconsin

Wisconsin

Wisconsin

Wisconsin

301 Hoffman Ave.

301 Hoffman Ave.

February 13 66

EDWARD FRANCIS BOOTH

Jan. 14/1892 71 0 29

Male White

Retired Barber (Barber Shop owner) Salisbury, Maryland D B A

Amate Bowling

Frank J. Booth

230-32-0562A Mrs. Gertrude M. Booth (Wife) 301 Hoffman Ave., Salisbury, Maryland

23

N/A

App-8:00p

Feb. 13/1966

X

E. Church St. Salisbury, Maryland

Dr. G. Herbert Semby

Butler Feb. 16/1966 Wisconsin Memorial Park Salisbury, Maryland

HOLLOMAN & COMPANY SALISBURY, MARYLAND

1
FOR STATE
HEALTH DEPT.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Traskin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>Lee</u> Last <u>Bowens</u>		4. DATE OF DEATH Month <u>2</u> Day <u>3</u> Year <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-65</u>
9. AGE (In years last birthday) yrs. <u>5</u> Months <u>20</u> Days <u>20</u> Hours <u>20</u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Roosevelt Bowens</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Reid</u>		15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. <u>Roosevelt Bowens - 416 Delaware Ave</u>		17. INFORMANT Address <u>Salisbury</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>525X</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		22. DATE SIGNED <u>2-6-66</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		Address (Street, city, town, or county) <u>1009 Camden Ave. Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2-6-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Traskin</u>	23d. LOCATION (City, town or county) (State) <u>Traskin, Md.</u>
24. FUNERAL DIRECTOR <u>Charles B. Jolley, Jersey Rd. Rt. 2</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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[Faint, illegible handwritten text covering the majority of the page]

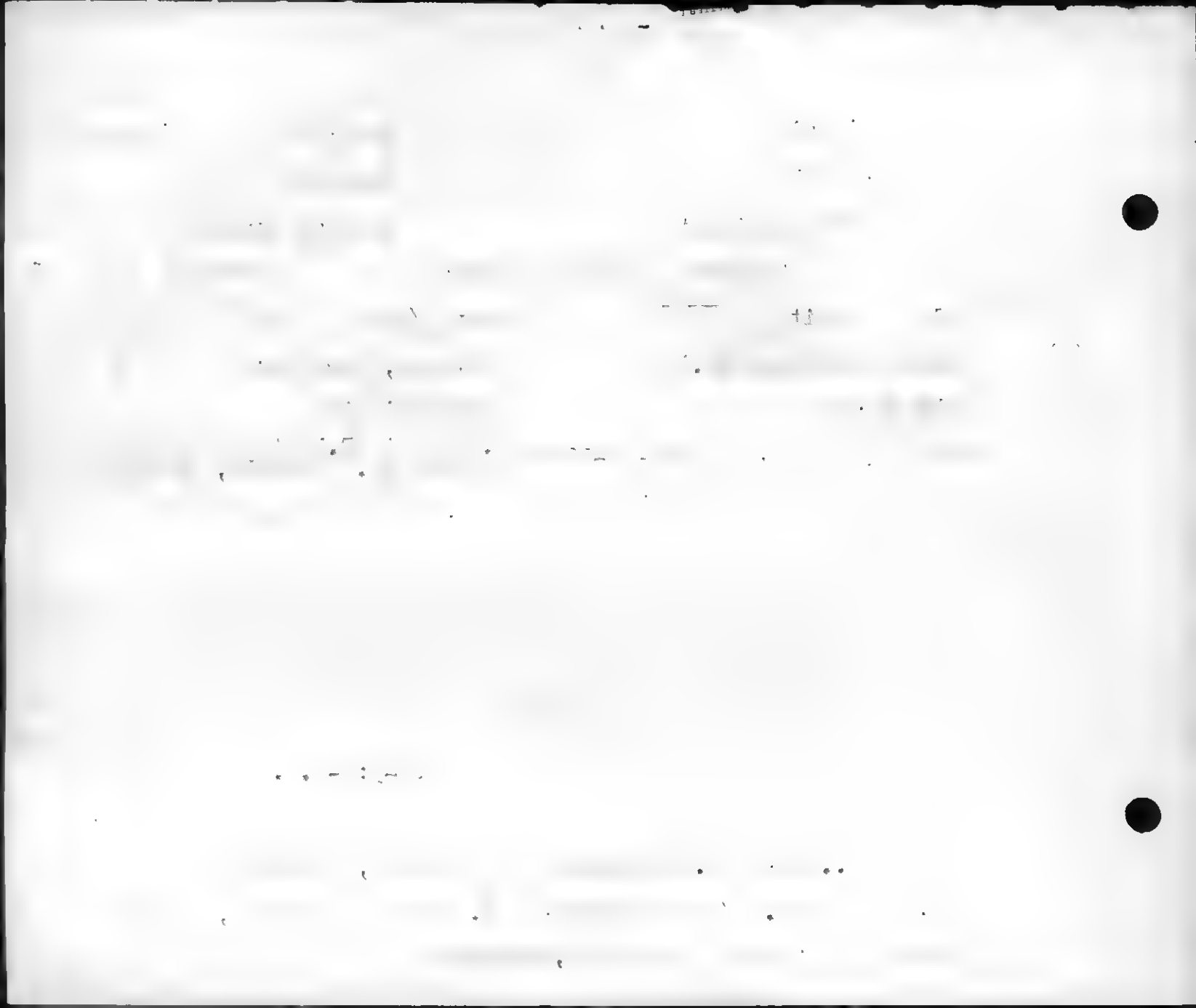
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>																					
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico															
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mardela						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mardela															
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Charles Street						d. STREET ADDRESS Charles Street															
3. NAME OF DECEASED (Type or print) CHARLES EDWARD BROWN						4. DATE OF DEATH February 12 1966															
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3/1879		9. AGE (in years last birthday) 86 yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td>7</td> <td>9</td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	7	9		
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
7	9																				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer (Package Co.)						10b. KIND OF BUSINESS OR INDUSTRY Mardela, Maryland		11. BIRTHPLACE (County & State, or foreign country) Mardela, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A											
13. FATHER'S NAME John Brown						14. MOTHER'S MAIDEN NAME Mary Phippin															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 217-09-1354		17. INFORMANT Mrs. Virginia M. Mezick (Daughter) Charles St. Mardela, Maryland													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decomposition (b) Coronary Arteriosclerosis (c) Arteriosclerosis, generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH 24 hrs 2 yrs 20 yrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) N/A						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from 12 Feb 1966 to 19 Feb 1966 that (I) (we) last saw the deceased alive on 12 Feb 1966 and that death occurred at 12 Feb 1966 from the causes and on the date stated above.																					
22a. SIGNATURE Dr. George G. Schlesinger						22b. DATE SIGNED Feb. 14-66		22c. PHYSICIAN'S NAME (Type) Dr. George G. Schlesinger													
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial						23b. DATE THEREOF Feb. 14/1966		23c. NAME OF CEMETERY OR CREMATORY Mardela Mem. Cemetery		23d. LOCATION (City, town or county) (State) Mardela, Maryland											
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY						25a. REC'D BY REGISTRAR FEB 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge													



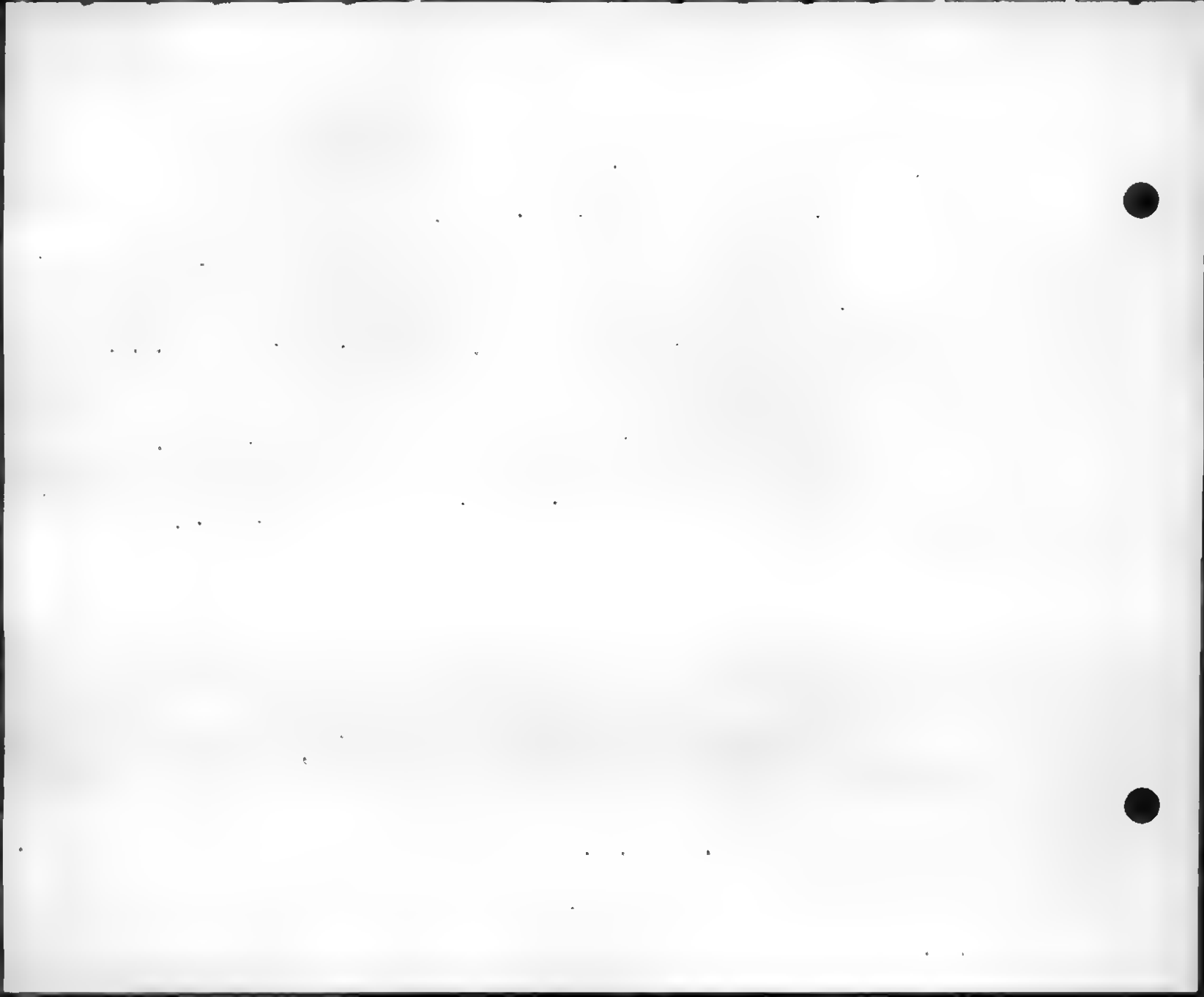
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02380 CERTIFICATE OF DEATH 02362

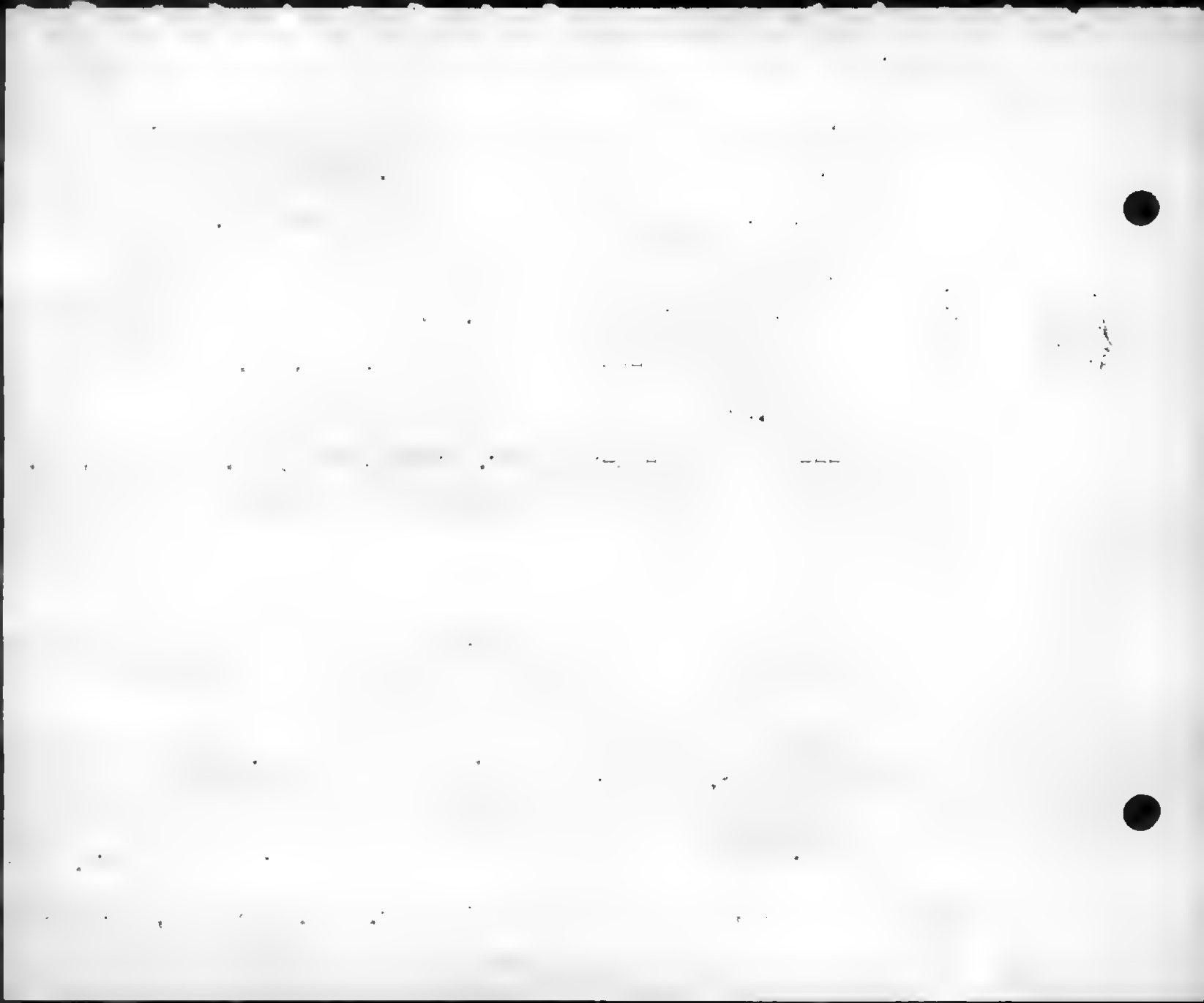
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>			
c. LENGTH OF STAY IN 1b <u>207 Days</u>				d. STREET ADDRESS <u>Rt. #2, Box 146</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital, Salisbury, Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>PHIL</u> Middle <u>BURTON</u> Last <u>BURTON</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>19 66</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 13, 1921</u>	
9. AGE (In years last birthday) <u>4</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Day laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fruit Canning Factory</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland, "Irish"</u>	
12. CITIZEN OF WHAT COUNTRY? <u>"Irish"</u>				13. FATHER'S NAME <u>Preston Burton</u>			
14. MOTHER'S MAIDEN NAME <u>Rebecca Wise</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>222-05-3676</u>				17. INFORMANT <u>Mrs. Cleodelia Burton, Denton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of rt. maxillary antrum with advanced metastases.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> , 19 <u>65</u> , to <u>2/21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/21</u> , 19 <u>66</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>V. Juerman</u>				22b. DATE SIGNED <u>2/21/66</u>		22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>	
22d. ADDRESS <u>Deer's Head State Hospital, Salisbury, Md.</u>				22e. REC'D BY REGISTRAR <u>FEB 24 1966</u>			
22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			
23b. DATE THEREOF <u>2-25-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Federal Hill, Maryland</u>				24. FUNERAL DIRECTOR <u>J. I. Brumpton and Son, Federal Hill, Maryland</u>			



1
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02281 CERTIFICATE OF DEATH 12263

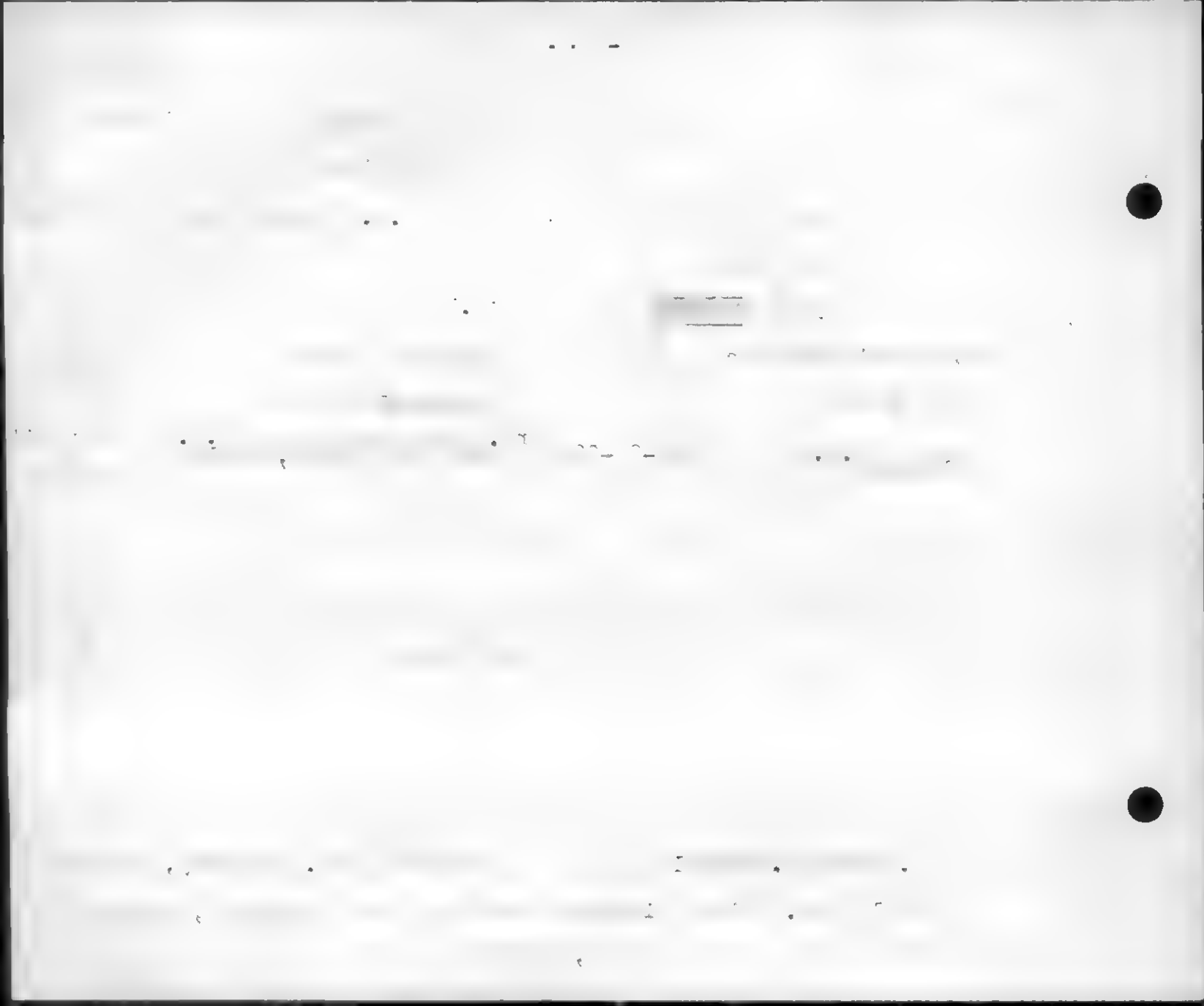
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels	
c. LENGTH OF STAY IN 1b 3 months		d. STREET ADDRESS 107 Carpenter St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Emily Carr		4. DATE OF DEATH Month Day Year 2 12 19 66	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 3, 1884
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 12 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) Talbot County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Schuyler		14. MOTHER'S MAIDEN NAME Kate Schuyler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-01-5719	
17. INFORMANT Mrs. Sarah Joshua, St. Michaels, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Old Cerebral Thrombosis with right Hemiparesis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 14, 1965 , to Feb. 12, 1966 , that (I) (we) last saw the deceased alive on Feb. 12, 1966 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE V. Juerman		22b. DATE SIGNED 2/12/66	
22c. PHYSICIAN'S NAME (Type) Dr. Juerman		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb 15, 1966	
23c. NAME OF CEMETERY OR CREMATORY Thomas Memorial Cem.		23d. LOCATION (City, town or county) (State) St. Michaels, Maryland	
24. FUNERAL DIRECTOR William H. Harrison		25a. REC'D BY REGISTRAR FEB 15 1966	
25b. REGISTRAR'S SIGNATURE Charles			



1
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M

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>					d. STREET ADDRESS <i>R.D.#4 Ocean City Rd</i>					
3. NAME OF DECEASED (Type or print) First <i>LOUIS</i> Middle <i>B</i> Last <i>Chamers</i>					4. DATE OF DEATH Month <i>February</i> Day <i>22</i> Year <i>1966</i>					
5. SEX <i>Male</i>		6. COLOR OR RACE <i>WHITE</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 16/1896</i>		9. AGE (In years last birthday) Months Days Hours Min. <i>70 yrs. 0 6</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Restaurant Operator</i>					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <i>Greece (Patras)</i>		
12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>					13. FATHER'S NAME <i>Bill Chamers</i>					
14. MOTHER'S MAIDEN NAME <i>Panagoula Fakos</i>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>YES W.W.#1</i>					
16. SOCIAL SECURITY NO. <i>220-32-0394</i>					17. INFORMANT <i>Mrs. Agnes Chamers (Wife)</i>					
18. ADDRESS <i>R.D.#4 Ocean City Rd Salisbury, Maryland</i>					19. WAS AUTOPSY PERFORMED? <i>YES</i> <input checked="" type="checkbox"/> <i>NO</i> <input type="checkbox"/>					
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> DUE TO (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1954</i> , 19__, to __, 19__, that (I) (we) last saw the deceased alive on <i>2/21/66</i> 19__, and that death occurred at <i>2 AM</i> , from the causes and on the date stated above.										
22a. SIGNATURE <i>Dr. Andrew C. Mitchell</i>					22b. DATE SIGNED <i>2/22/66</i>					
22c. PHYSICIAN'S NAME (Type) <i>Dr. Andrew C. Mitchell</i>					22d. ADDRESS <i>Maryland Ave. Salisbury, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <i>Feb. 25/1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Wicomico Memorial Park</i>			23d. LOCATION (City, town or county) (State) <i>Salisbury, Maryland</i>		
24. FUNERAL DIRECTOR <i>HOLLOWAY & COMPANY SALISBURY, MARYLAND</i>					25a. REC'D BY REGISTRAR <i>FEB 23 1966</i>					
					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

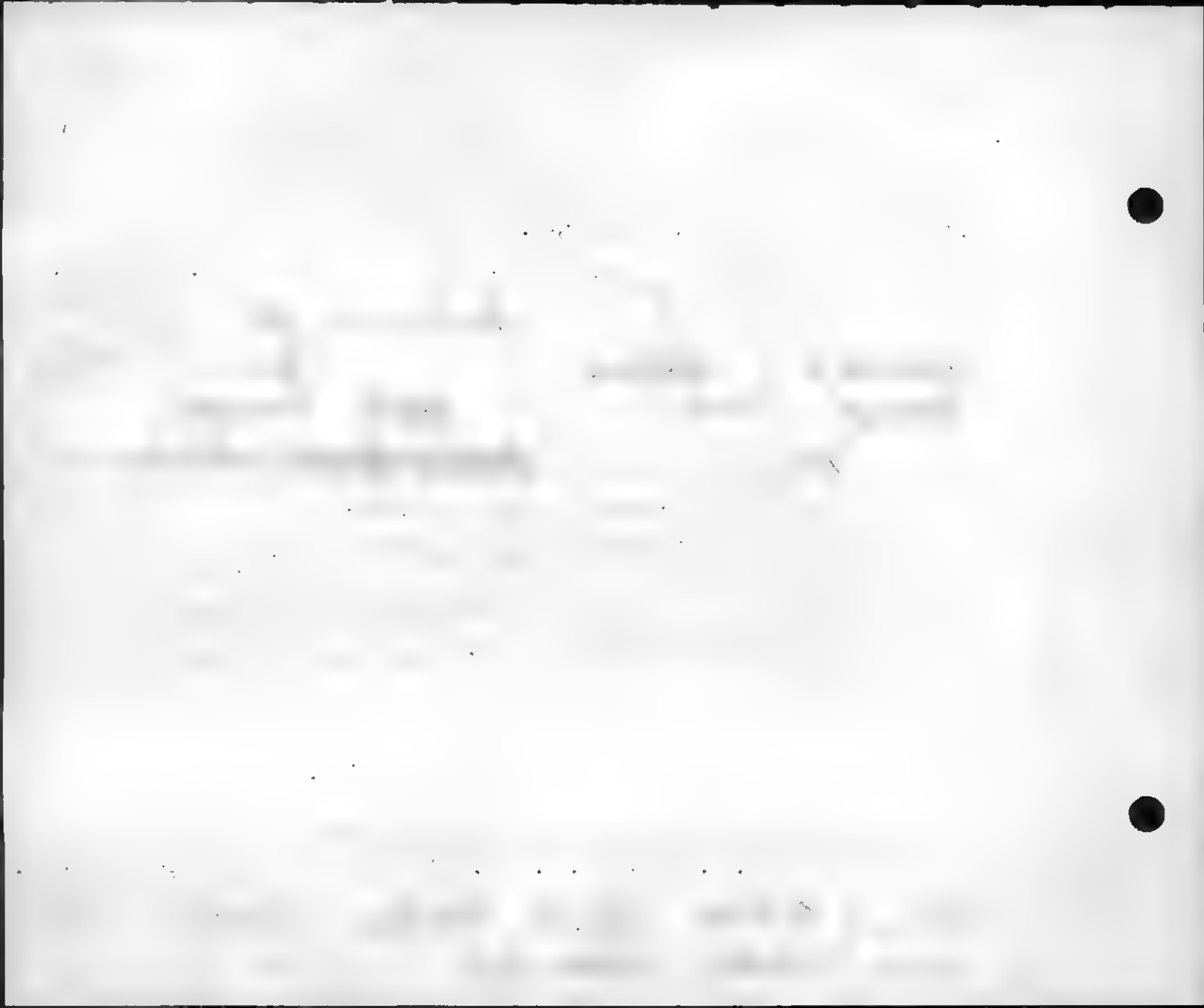


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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Grasonville	
c. LENGTH OF STAY IN 1b 11 Days		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lola Middle Gertrude Last Chester		4. DATE OF DEATH Month Feb. Day 4 Year 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1913
9. AGE (in years last birthday) 52 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 3 Days 2 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vincent Cook		14. MOTHER'S MAIDEN NAME Katie Conyer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Hospital Records		Address Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebral thrombosis 47-8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral bronchopneumonia; diabetes.		INTERVAL BETWEEN ONSET AND DEATH 1964, 1966 Years	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/24 , 19 66 , to 2/4/66 , 19 66 , that (I) (we) last saw the deceased alive on 2/4 , 19 66 , and that death occurred at 9:55 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE L. V. Maldve		22b. DATE SIGNED 2/7/66	
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		23b. DATE THEREOF 2-9-66	
23c. NAME OF CEMETERY OR CREMATORY Christie Cemetery		23d. LOCATION (City, town or county) (State) Christie Md.	
24. FUNERAL DIRECTOR James B. Washburn		25a. REC'D BY REGISTRAR DATE FEB 10 1966	
25b. REGISTRAR'S SIGNATURE James B. Washburn		25c. REGISTRAR'S SIGNATURE James B. Washburn	



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Accomack</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Accomack, Va.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LYBRIGHT</u> Middle <u>H.</u> Last <u>CLARK</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>11</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 8, 1911</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	9. AGE (in years last birthday) <u>55</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Matthew Clark</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Evans</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>230-425397</u>	
17. INFORMANT <u>Dorothy Clark</u>		Address <u>Accomack, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO (b) <u>Hypertension</u> and DUE TO (c) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/10/1966</u> to <u>2/11/1966</u> ; that (I) (we) last saw the deceased alive on <u>2/11/1966</u> , and that death occurred at <u>2:50</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 15, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wharton mem. Parkersley, Va.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>Edgar Wharton - Accomack, Va.</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>FEB 16 1966</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

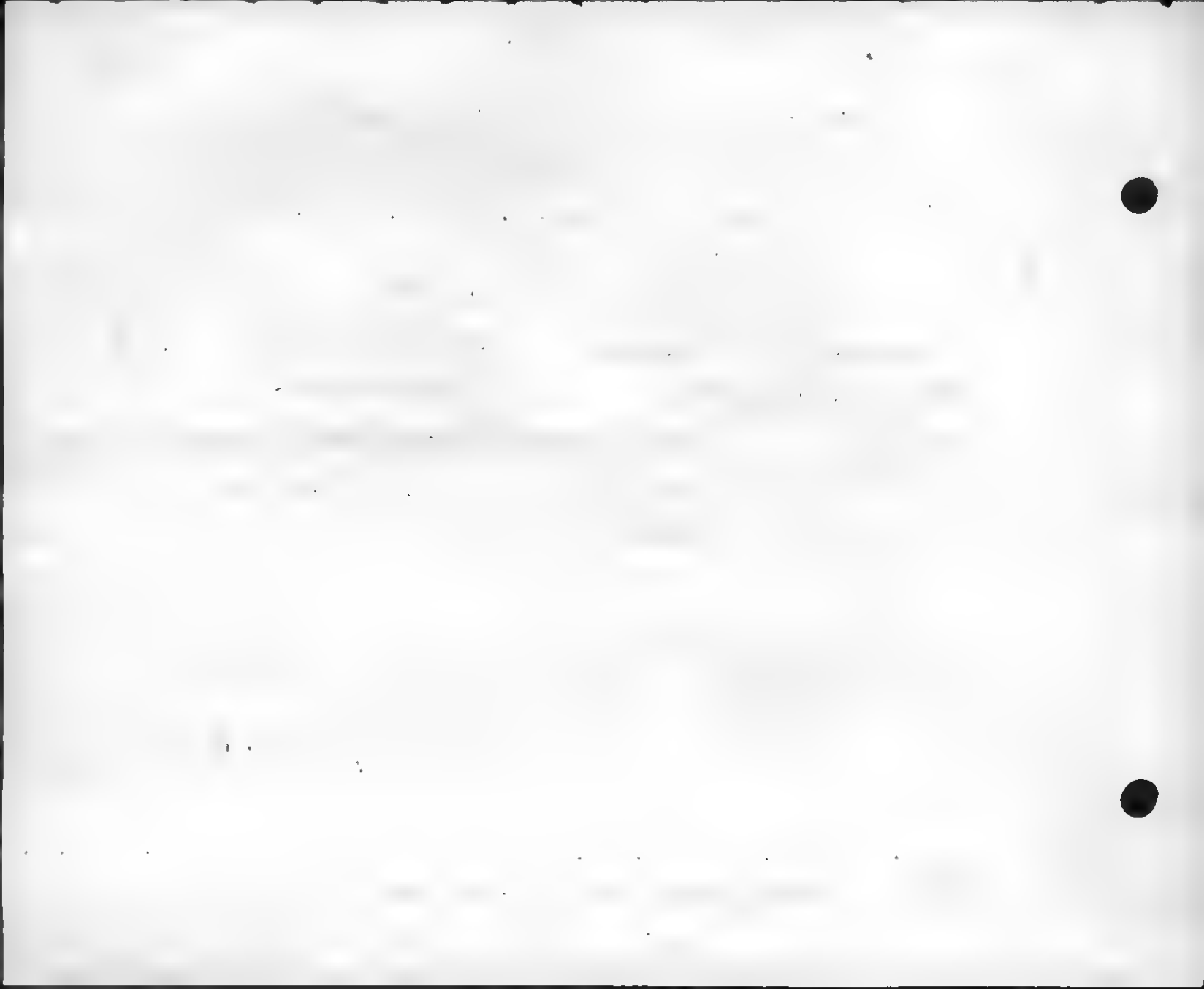
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
c. LENGTH OF STAY IN 1b <u>6 days</u>		d. STREET ADDRESS <u>306 Hanson Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital, Salisbury, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Roland</u> Middle <u>Clark</u> Last <u>Clark</u>		4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1899</u>
9. AGE (in years last birthday) <u>66</u> yrs. Months <u>6</u> Days <u>7</u> Hours <u></u> Min. <u></u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SALESMAN</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>CAROLINE COUNTY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES MARINE CLARK</u>		14. MOTHER'S MAIDEN NAME <u>LONA TOWERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-01-8408</u>	
17. INFORMANT <u>MRS. ROLAND CLARK</u>		Address <u>EASTON - MD. 21601</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema with bilateral Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Recurrent Cerebral Stroke</u> DUE TO (c) <u>Right Carotid Artery Stenosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>2 Months</u> <u>2 Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Right Hemiparesis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>February 1, 1966</u> , to <u>Feb. 7, 1966</u> , that (I) (we) last saw the deceased alive on <u>February 7, 1966</u> , and that death occurred at <u>10PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>2/8/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. F. Gutierrez-Garrido, M.D.</u>		22d. ADDRESS <u>Deer's Head State Hospital, Salis. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>FEBRUARY 10, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>	23d. LOCATION (City, town or county) (State) <u>EASTON - MARYLAND</u>
24. FUNERAL DIRECTOR <u>[Signature]</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>	
ADDRESS <u>Easton, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
DATE <u>FEB 11 1966</u>			



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN ID Parsonsbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS House 2	
3. NAME OF DECEASED (Type or print) First JERRY Middle LEE Last DAVIS		4. DATE OF DEATH Month 2 Day 1 Year 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 2, 1950
9. AGE (In years last birthday) 15 yrs.		10. IF UNDER 1 YEAR Months 15 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Elementary School	
11. BIRTHPLACE (State or foreign country) Milford, Del.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ernest Davis		14. MOTHER'S MAIDEN NAME Margie Lynch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ernest Davis, Parsonsbury, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic acidosis. 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH long year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED 2-1-66	
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/4/66	23c. NAME OF CEMETERY OR CREMATORY Parsonsbury Cemetery	23d. LOCATION (City, town or county) (State) Parsonsbury, Md.
24. FUNERAL DIRECTOR Dennis Funeral Home, Snow Hill, Md.		25a. REC'D BY REGISTRAR FEB 8 1966	
		25b. REGISTRAR'S SIGNATURE Judge	

TO COUNTY HEALTH DEPARTMENT: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

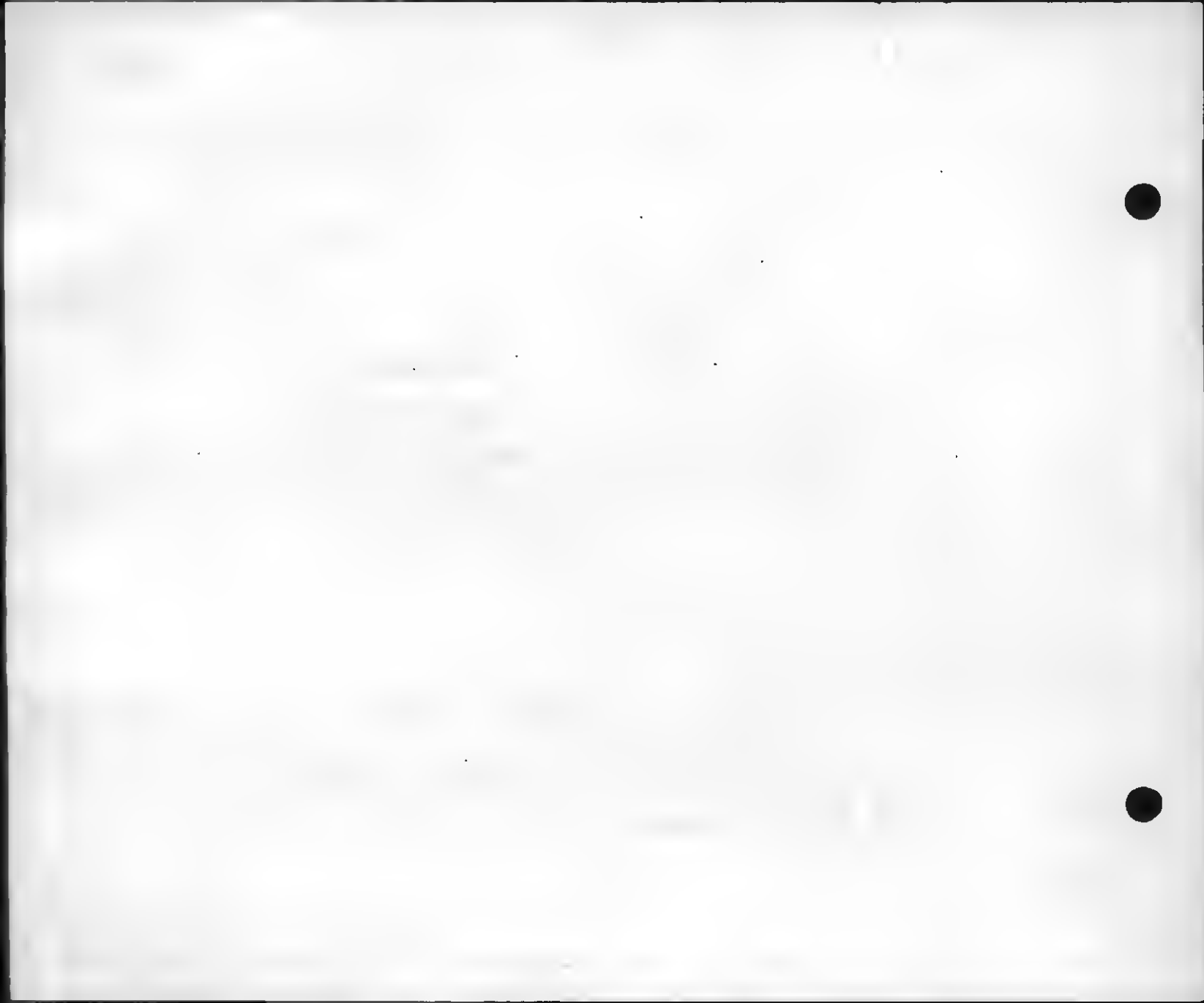
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

<p>1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u></p>		<p>2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Snow Hill</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First <u>Watson</u> Middle <u>D.</u> Last <u>DICKERSON</u></p>		<p>4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1966</u></p>	
<p>5. SEX <u>Male</u></p>	<p>6. COLOR OR RACE <u>White</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>Sept. 3, 1908</u></p>
<p>9. AGE (In years last birthday) <u>57</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u></p>	
<p>10a. BIRTHPLACE (County & State, or foreign country) <u>Worcester Co. Maryland</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>Marion Dickerson</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Mary E. Burke</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO. <u>213 16 7606</u></p>	<p>17. INFORMANT Address <u>Pearl Pennewell, Snow Hill, Md.</u></p>
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO <u>Obstructive Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5+71</u> DUE TO (c)</p>			<p>INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>years</u></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>			
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>	
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u></p>	<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work</p>	<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>	<p>20f. (City or town) (County) (State)</p>
<p>21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10, 1966</u> to <u>Feb 17, 1966</u>, that (I) (we) last saw the deceased alive on <u>Feb 16, 1966</u>, and that death occurred at <u>4:30</u> M. from the causes and on the date stated above.</p>			
<p>22a. SIGNATURE <u>David Rafat M.</u></p>		<p>22b. DATE SIGNED <u>2-19-66</u></p>	<p>22c. PHYSICIAN'S NAME (Type) <u>DAVID RAFAT</u></p>
<p>22d. ADDRESS <u>Snow Hill Md.</u></p>		<p>22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>23b. DATE THEREOF <u>2-19-66</u></p>	<p>23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u></p>	<p>23d. LOCATION (City, town or county) (State) <u>Snow Hill Md.</u></p>
<p>24. FUNERAL DIRECTOR <u>Thomas F. Morris</u></p>		<p>25a. REC'D BY REGISTRAR <u>Charles Judge</u></p>	
<p>25b. REGISTRAR'S SIGNATURE</p>		<p>DATE <u>FEB 21 1966</u></p>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

02588

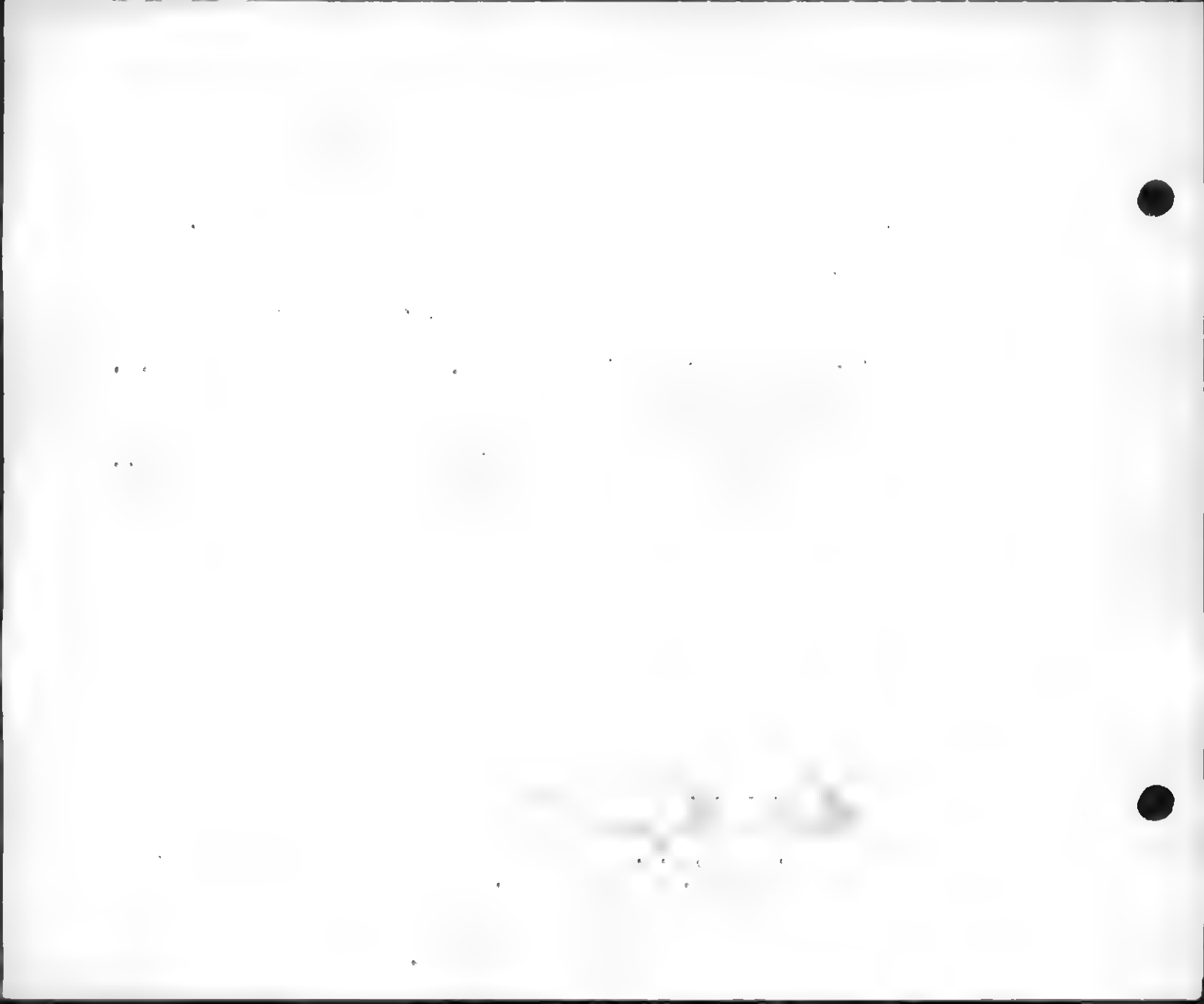
02972

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Snow Hill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		e. STREET ADDRESS 413 Covington St.	
3 NAME OF DECEASED (Type or print) Elenora Drummond		4 DATE OF DEATH Month 2 Day 27 Year 66	
5 SEX F	6 COLOR OR RACE AA	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-27-12
9 AGE (In years last birthday) 54 yrs		10 IF UNDER 1 YEAR Months 1 Days 19 Hours 19 Min 19	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		11b. KIND OF BUSINESS OR INDUSTRY Domestic	
12 BIRTHPLACE (State or foreign country) Md.		13 CITIZEN OF WHAT COUNTRY? U.S.A.	
14 FATHER'S NAME Curtis Bishop		15 MOTHER'S MAIDEN NAME Lottie Short	
16 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		17 SOCIAL SECURITY NO Shirley Johnson, Snow Hill, Md.	
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 5-27-66 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH hours	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED 3-1-66	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		Address (Street, city, town, or county) 409 Camden Ave. Salisbury, Md.	
23a. BURIAL CREMATION REMOVED Burial	23b. DATE OF BURIAL 3/5/66	23c. NAME OF CEMETERY OR CREMATORY Cool Spring Cem.	23d. LOCATION (City or Town) (County) (State) Girdletree, Md.
24. FUNERAL DIRECTOR Samuel Savage		25a. RECD BY REGISTRAR New Church, Va.	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DATE **MAR 7 1966**



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02989

02973

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>1WK</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Yninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>1036 E. MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>John Henry Dyer</u> First Middle Last				4. DATE OF DEATH <u>February 8 1966</u> Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 14, 1900</u>		9. AGE (In years last birthday) <u>65</u> yrs. IF UNDER 1 YEAR: Months <u>21</u> Days <u>21</u> Hours <u>21</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REL. PRINTER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Comm'l</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>MELVIN DYER</u>				14. MOTHER'S MAIDEN NAME <u>JOANNE BROWN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>161-10-5853</u> 17. INFORMANT <u>MRS. JOHN H. DYER, SAME</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undifferentiated Carcinoma Bronchus</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12/24/65</u> 19 <u>to</u> <u>2/8/66</u> 19 <u>that (I) (we) last saw the deceased alive on</u> <u>2/7/66</u> 19 <u>and that death occurred at</u> <u>4:05</u> AM <u>from the causes and on the date stated above.</u>									
22a. SIGNATURE <u>A.C. MITCHELL</u> 22b. PHYSICIAN'S NAME (Type) <u>A.C. MITCHELL - M.D.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>MARYLAND AVE. SALISBURY, MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/10/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico MEM. PARK</u>		23d. LOCATION (City, town or county) (State) <u>SALISBURY, MD.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry C. Hill</u>				25a. REC'D BY REGISTRAR <u>EEB 11 1966</u> 25b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



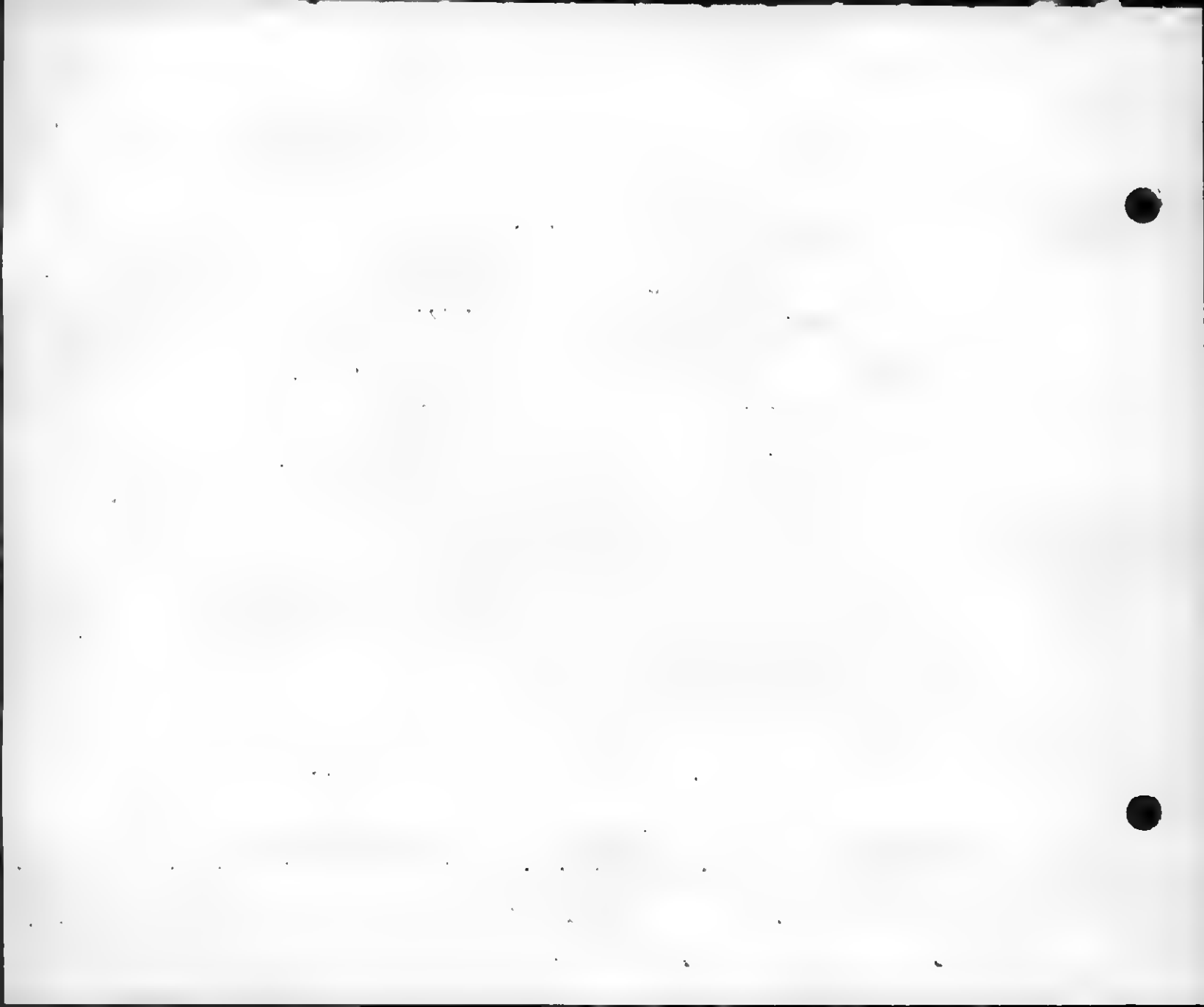
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

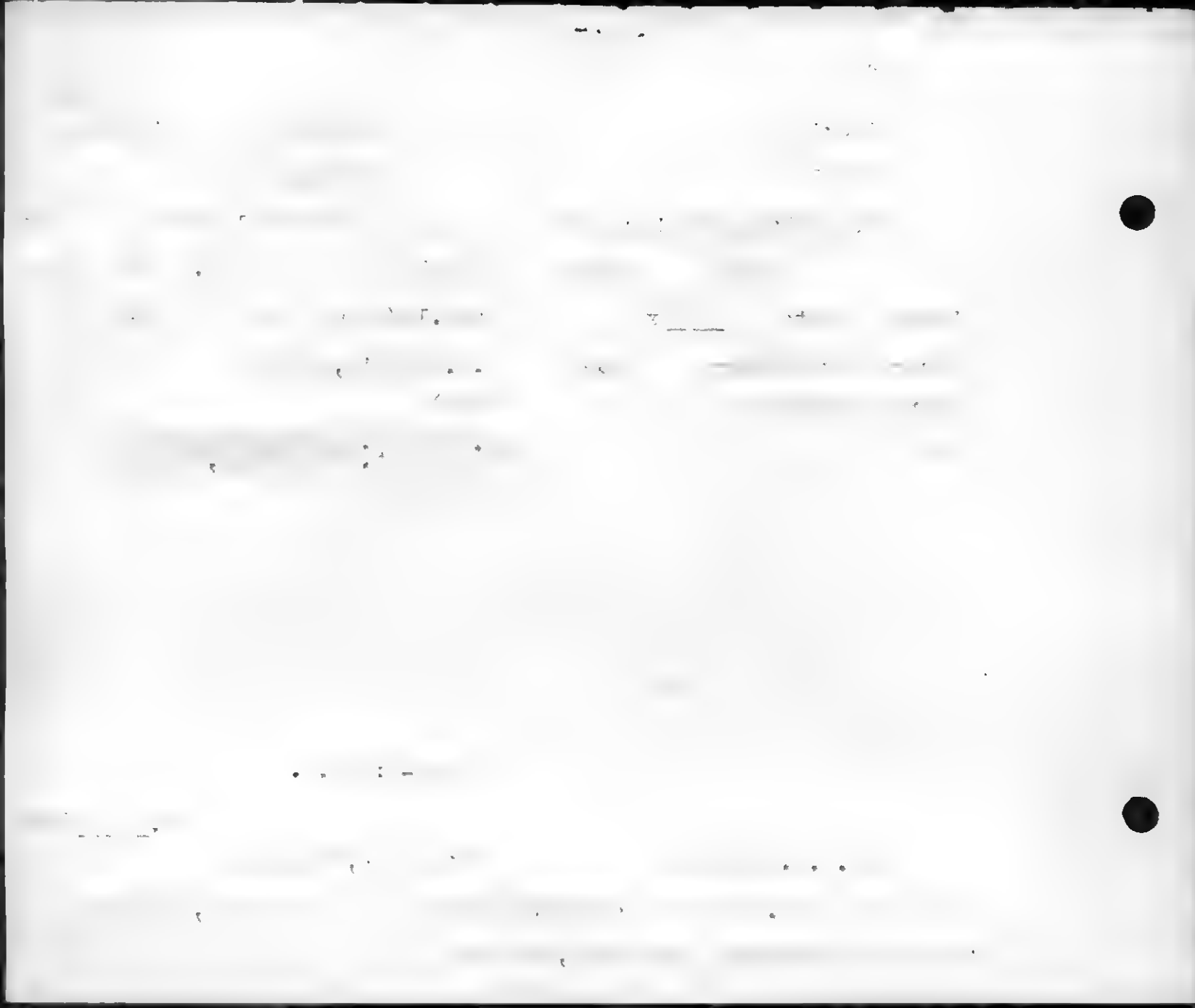
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 101 Days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.				d. STREET ADDRESS Chester			
3. NAME OF DECEASED (Type or print) First Ogle Middle Tilghman Last Eaton				4. DATE OF DEATH Month 2 Day 4 Year 19 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 1, 1886	
9. AGE (in years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 66 Min.		11. BIRTHPLACE (County & State, or foreign country) Chester, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Ogle Tilghman Eaton				14. MOTHER'S MAIDEN NAME Amelia Edenfield			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Roy Eaton--Chester, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 551X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, General DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 9 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/26 , 19 65 to 2/4 , 19 66 , that (I) (we) last saw the deceased alive on 2/4 , 19 66 , and that death occurred at 10:15 PM , from the causes and on the date stated above.							
22a. SIGNATURE V. Juerman						22b. DATE SIGNED 2/7/66	
22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.				22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 7		23c. NAME OF CEMETERY OR CREMATORY Stevensville		23d. LOCATION (City, town or county) (State) Stevensville, Maryland	
24. FUNERAL DIRECTOR Edgar L. Lane				25a. REC'D BY REGISTRAR Feb 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02991
CERTIFICATE OF DEATH
02077

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mardela		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Maple Shade Nursing Home		d. STREET ADDRESS 215 Marshall Street	
3. NAME OF DECEASED (Type or print) First DORA Middle MAE Last ENNIS		4. DATE OF DEATH Month FEB. Day 10 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 14/1880
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 4 Days 26 Hours Min. 	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work at home		11b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) R.D.#Berlin, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Norris Holloway		14. MOTHER'S MAIDEN NAME (Unk)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Ms. Helen E. Windsor (Daughter) 215 Marshall St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage IX DUE TO (b) General Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Pneumonia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 6, 1963 to 2/10 , 19 66 , that (I) (we) last saw the deceased alive on Feb 10 , 19 66 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE H.S. Kuhlman		22b. DATE SIGNED Feb. 12 /1966	
22c. PHYSICIAN'S NAME (Type) DR. H.S. Kuhlman		22d. ADDRESS Sharptown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 13/1966	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION (City, town or county) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR FEB 17 1966	25b. REGISTRAR'S SIGNATURE Phyllis Judge



MARYLAND STATE DEPARTMENT OF HEALTH

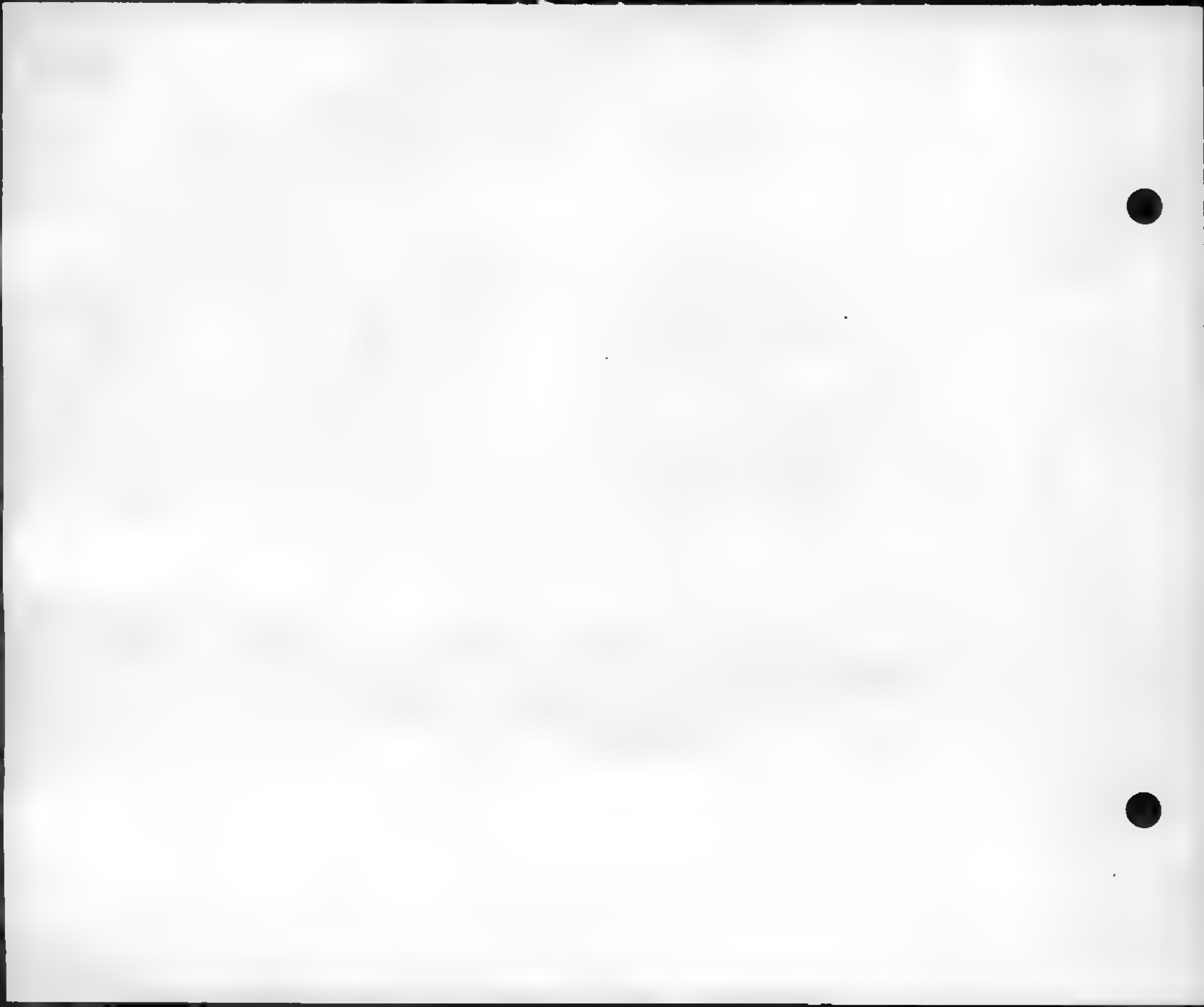
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02292

12078

1. PLACE OF DEATH a. COUNTY <u>Accomack</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>RFD New Church</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>BEULAH ETHEL FLETCHER</u>		4. DATE OF DEATH <u>FEB. 14</u> 19 <u>66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 17, 1900</u> 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Accomack, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Fletcher</u>		14. MOTHER'S MAIDEN NAME <u>Licia Fields</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>229-09-9064</u>	
17. INFORMANT <u>Margie Fletcher</u>		Address <u>Pocomoke City, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSES</u> <u>1528</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ADENOCARCINOMA COLON</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>APP 12 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/18</u> , 19 <u>66</u> , to <u>2/14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/14</u> , 19 <u>66</u> , and that death occurred at <u>6:45 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John M. Bloxom</u>		22b. DATE SIGNED <u>2/14/1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN M. BLOXOM</u>		22d. ADDRESS <u>Medical Center, Salisbury, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-20-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Methodist</u>	23d. LOCATION (City, town or county) (State) <u>Withams, Va.</u>
24. FUNERAL DIRECTOR <u>C. L. Humbles</u>		25a. REC'D BY REGISTRAR <u>FEB 18 1966</u>	
ADDRESS <u>Accomack, Va.</u>		25b. REGISTRAR'S SIGNATURE <u>John M. Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

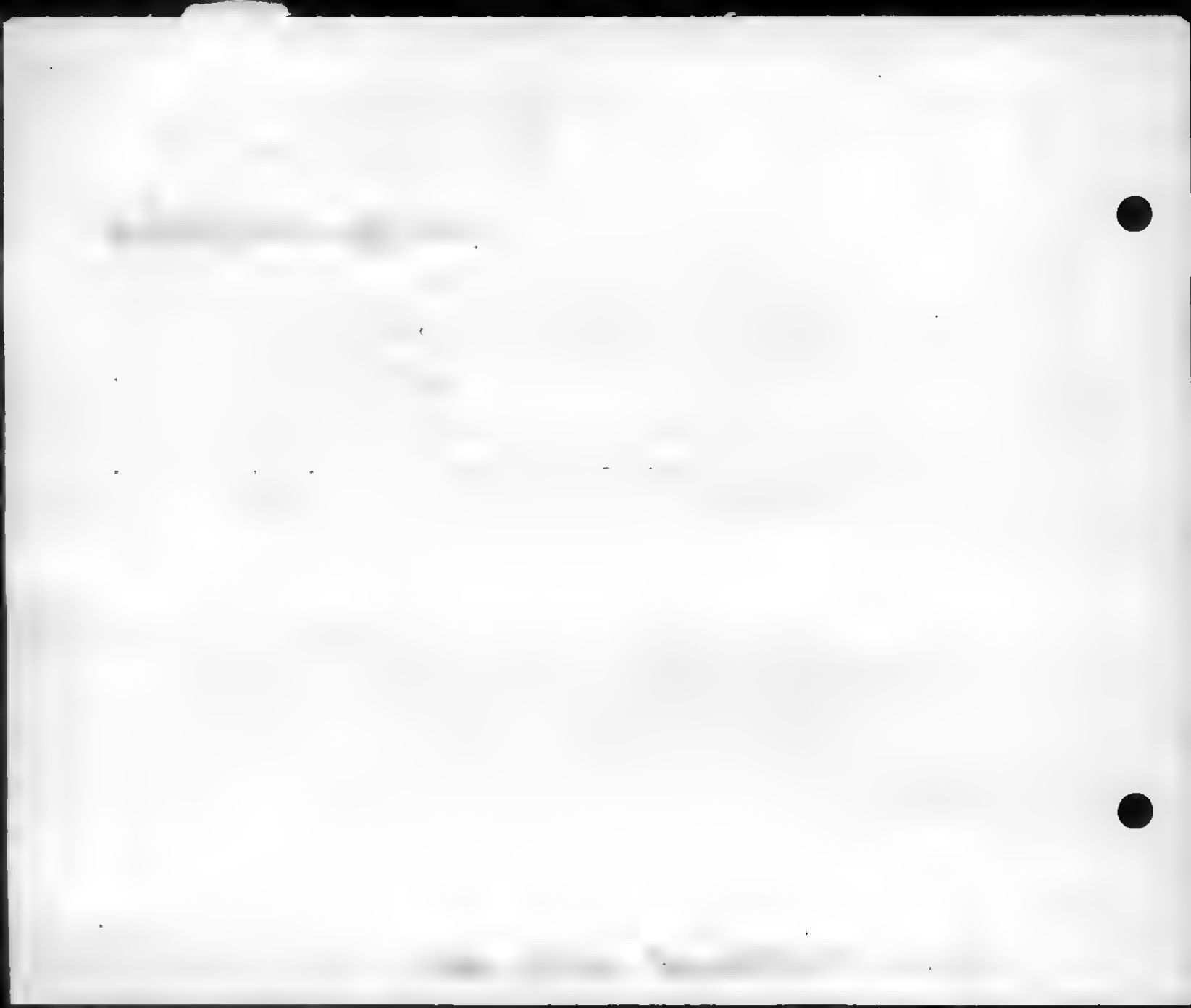


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~There~~ please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wilcomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wilcomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>post office Box Fruitland</u>	
3. NAME OF DECEASED (Type or print) <u>ELEANOR MARIE GARDNER</u>		4. DATE <u>DEATH</u> <u>FEBRUARY 19 1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 1, 1933</u>
9. AGE (in years last birthday) <u>32</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick Waters</u>		14. MOTHER'S MAIDEN NAME <u>Annie Wright</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-36-1356</u>	
17. INFORMANT <u>Emiley Wright R.F.D. 2 Eden Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subacute Bacterial Endocarditis</u> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/22 4</u> , 19 <u>66</u> , to <u>2/19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/19</u> , 19 <u>66</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>David J. Gilmore</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>David J. Gilmore, M.D.</u>		22d. ADDRESS <u>Medical Center, Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/22/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Eden</u>	23d. LOCATION (City, town or county) (State) <u>Eden Md.</u>
24. FUNERAL DIRECTOR <u>Clinton F. Stewart</u> ADDRESS <u>Salisbury Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 28 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

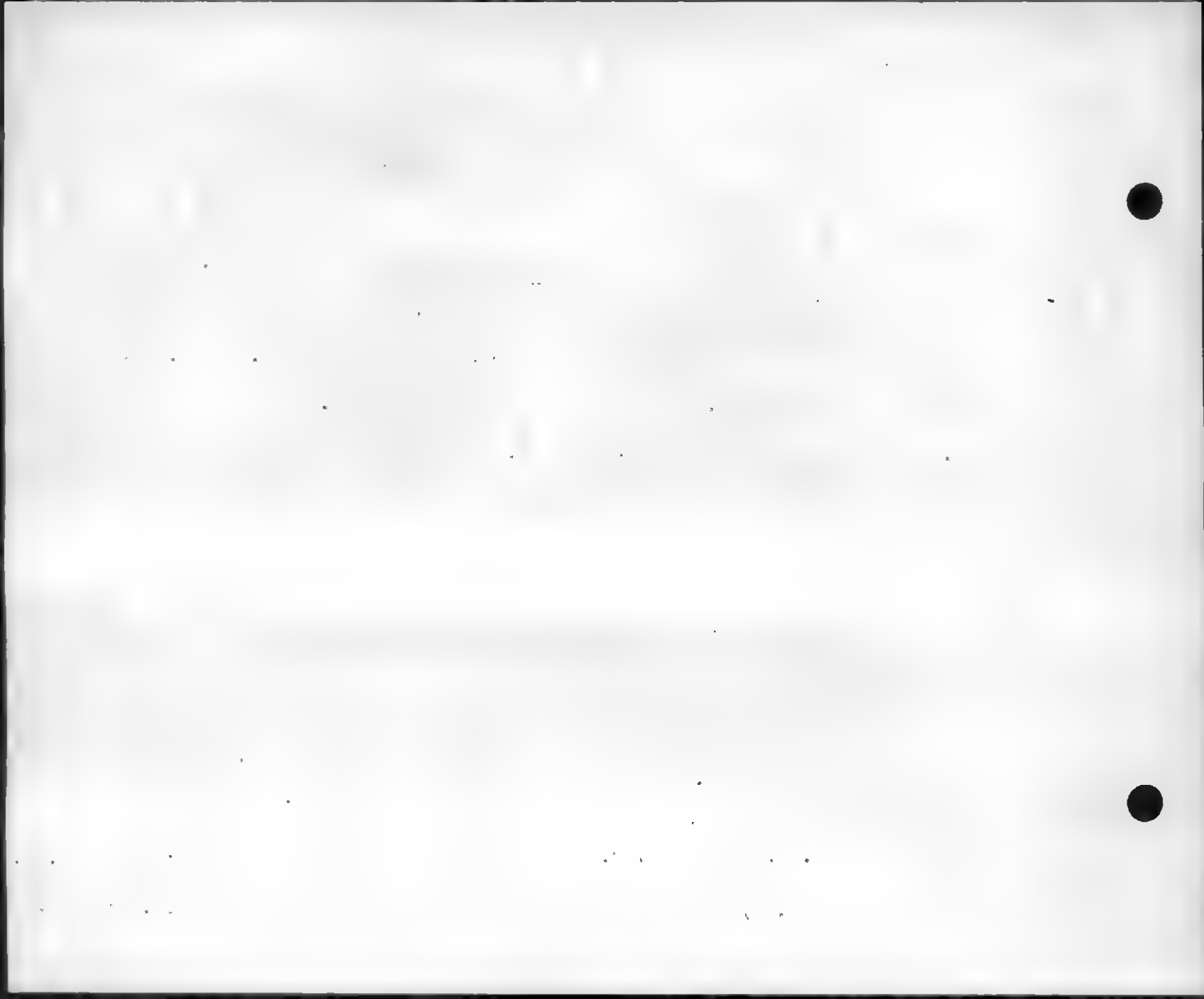


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12294 CERTIFICATE OF DEATH 12280

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 77 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Gertrude Middle Goodhand Last Goodhand				4. DATE OF DEATH Month Feb. Day 14 Year 19 66			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 1, 1878	
9. AGE (in years last birthday) 87 yrs.		10. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (County & State, or foreign country) Queen Anne's Co; Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Sturgis Goodhand.				14. MOTHER'S MAIDEN NAME Eugenia Sudler.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. 217-36-1731		17. INFORMANT Wm. Sudler Goodhand, Sudlersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of right breast with metastasis and mastectomy 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 22 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive arteriosclerotic cardiovascular disease							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/29 , 19 65 , to Feb. 14 , 19 66 , that (I) (we) last saw the deceased alive on Feb. 14 , 19 66 , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE L. V. Maldve, M. D.				22b. DATE SIGNED 2:30 P.M. 2/14/66			
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.				22d. ADDRESS Deer's Head State Hospital; Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 17, 1966		23c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery		23d. LOCATION (City, town or county) (State) Sudlersville, Q.A.Co; Md.	
24. FUNERAL DIRECTOR Charles Judge				25a. REC'D BY REGISTRAR FEB 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

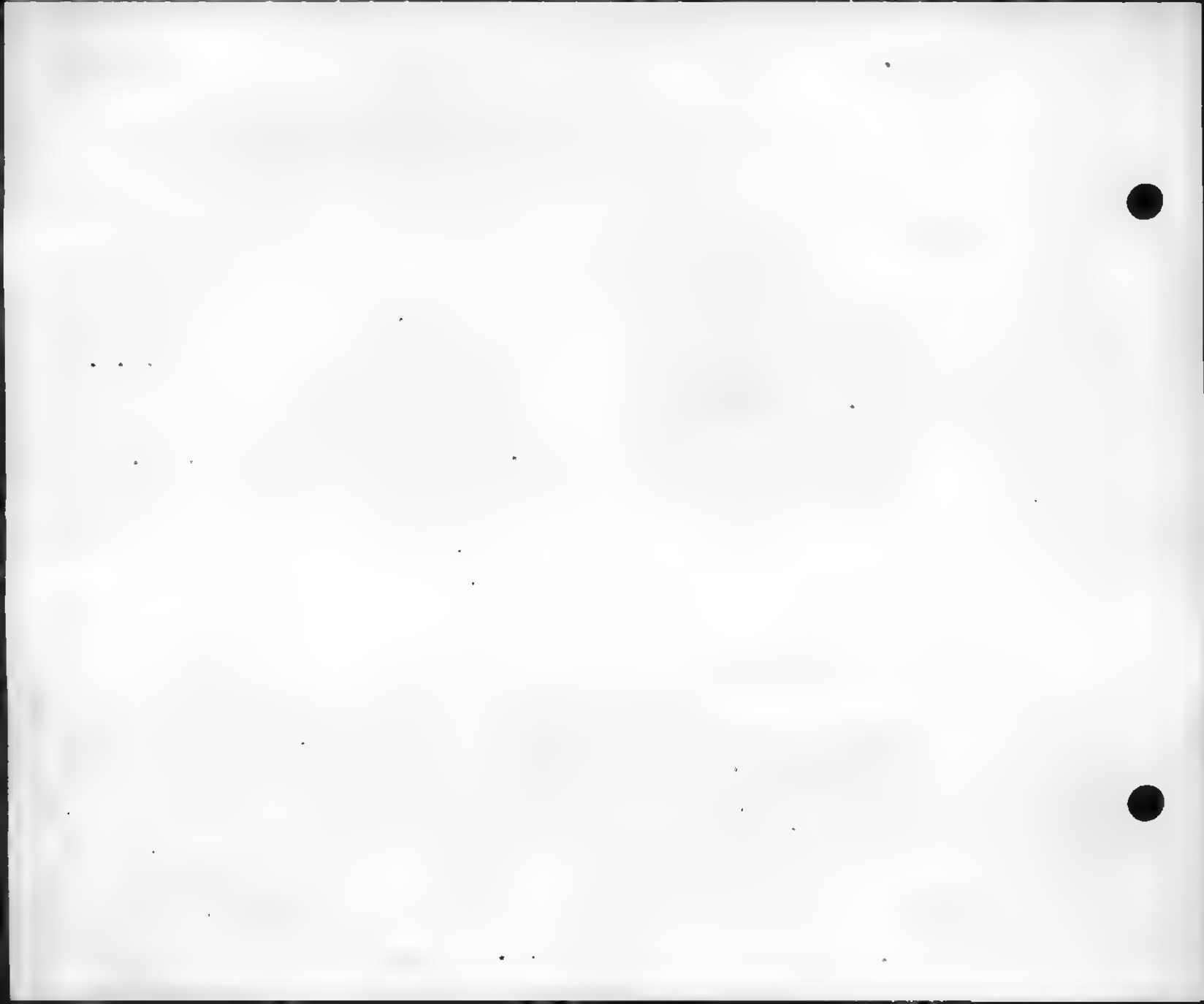
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

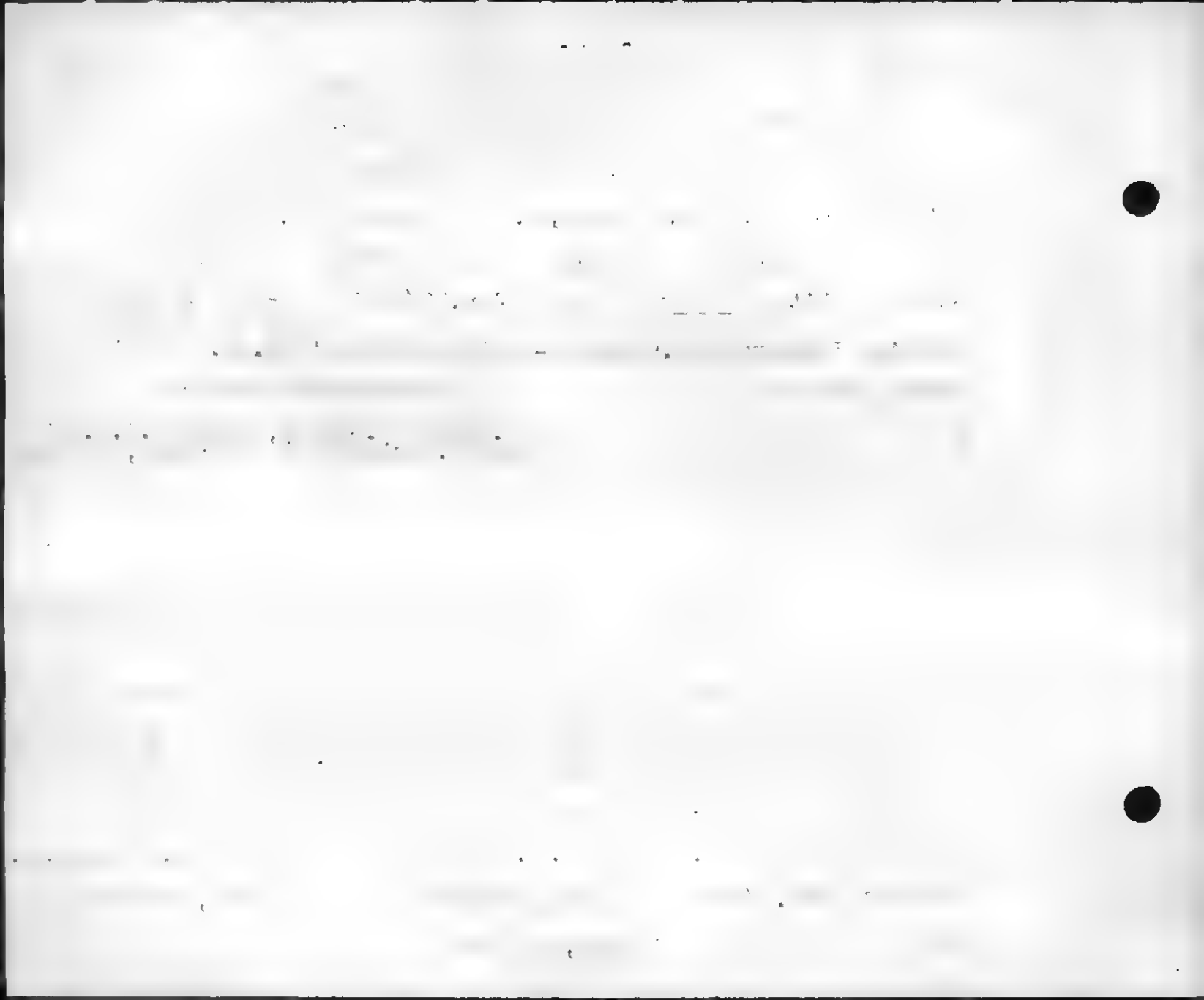
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>QUANTICO</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LETHEL Disharoon GORDY</u>		4. DATE OF DEATH <u>FEBRUARY 21 1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 28, 1894</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MERCHANDISE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELMER T. DISHARON</u>		14. MOTHER'S MAIDEN NAME <u>LILLIE SMOOT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MR. HERMAN GORDY</u>		Address <u>QUANTICO, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Attack</u> DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>Yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-16-66</u> , 19 <u>66</u> , to <u>2-21-66</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>2-13-66</u> , 19 <u>66</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>HABriele</u>		22b. DATE SIGNED <u>2-22-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>HABriele</u>		22d. ADDRESS <u>Medical Center Salisbury Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/24/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>QUANTICO CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>QUANTICO, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>LEVIN R. WILSON</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 1 1966</u>	



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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Item 18 Film G373 2, MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02996
12382
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 20 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.				d. STREET ADDRESS 403 Hastings St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Frances Last Shores Gross				4. DATE OF DEATH Month Feb. Day 6 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 13/1893	9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 0 Days 13 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sunshine Laundry (Mach. Operator-Retired)				10b. KIND OF BUSINESS OR INDUSTRY Somerset Co. Md.		11. BIRTHPLACE (County & State, or foreign country) U S A	
13. FATHER'S NAME Jessie Messick				14. MOTHER'S MATEOEN NAME Susan Messick Messick			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mr. Norman W. Shores, Sr (Son) P.O.B. #41 812 S. Division St. Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 177d DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pancreas or ovary DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 1 Year 2
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/17 , 19 66 , to 2/6 , 19 66 , that (I) (we) last saw the deceased alive on 2/6 , 19 66 and that death occurred at 2:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE V. Juerman M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/7/66	
22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.				22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 9/1966		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR FEB 10 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



1 **M**

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> c. LENGTH OF STAY IN 1b <i>10 hours</i> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Delaware</i> b. COUNTY <i>Sussex</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Seabrook</i> d. STREET ADDRESS <i>46-3</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>David Franklen</i> First Middle Last 4. DATE OF DEATH <i>February 28 1966</i> Month Day Year		5. SEX <i>Male</i> 6. COLOR OR RACE <i>Colored</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>Nov 5, 1965</i> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <i>3</i> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Wicomico Co Salisbury Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Harrison Hall</i>		14. MOTHER'S MAIDEN NAME <i>Irene Monk</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Irene Monk Hall</i>		Address <i>Seabrook, Del</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> <i>441X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>2/28</i> , 19 <i>66</i> to <i>4/28</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>19</i> , and that death occurred at <i>7:15</i> PM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Alfred C. Green</i>		22b. DATE SIGNED <i>2/28/66</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>Medical Center Salisbury, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>Mar. 2, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Heimantown</i>		23d. LOCATION (City, town or county) (State) <i>Berlin Md.</i>	
24. FUNERAL DIRECTOR <i>Henry N. Watson</i>		25a. -REC'D BY-REGISTRAR <i>Charles Judge</i>	
ADDRESS <i>Wicomico City, Md.</i>		25b. REGISTRAR'S SIGNATURE	



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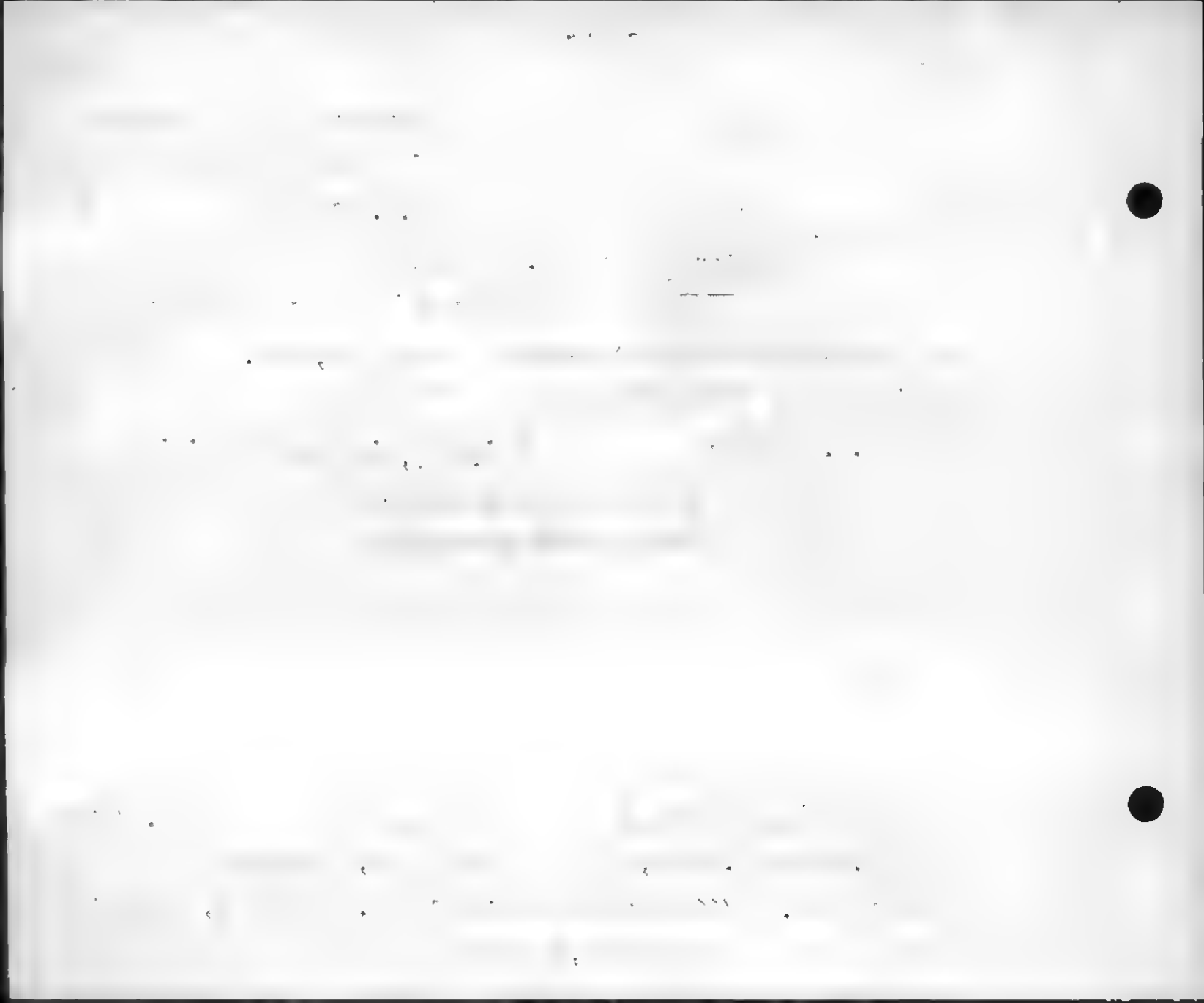
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury (Rural)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>R.D.# 1</u>	
3. NAME OF DECEASED First Middle Last <u>Frederick Ernest Geo. HEYSE</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY 1 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18/1924</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>City Administrator (Manager) Pocomoke</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bridgeport, Conn.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Frederick George Ernest Heyse</u>		14. MOTHER'S MAIDEN NAME <u>Helen Tearne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>W.W.#11 (Navy)</u>	
17. INFORMANT <u>Mrs. Nancy C. Heyse (Wife)</u>		Address <u>R.D.#1 Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>4201</u> DUE TO <u>Coronary atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>Coronary atherosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>MIN.</u> <u>YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>3-29</u> , 19 <u>66</u> , to <u>2-1</u> , 19 <u>66</u> , that <u>we</u> last saw the deceased alive on <u>12-28</u> , 19 <u>66</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Hubert R. White, Jr.</u>		22b. DATE SIGNED <u>Feb. 2/1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Hubert R. White, Jr.</u>		22d. ADDRESS <u>Fruitland, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
<u>Burial</u>	<u>Feb. 7 /66</u>	<u>Arlington National Cem.</u>	<u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

MEDICAL CERTIFICATION



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 5 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 318 Boulden Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ferman	4. DATE OF DEATH Feb. 26 1966	5. SEX Male	
6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883	9. AGE (In years last birthday) 82 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Mo		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm Hicks		14. MOTHER'S MAIDEN NAME Lonnie Quinn	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT ---		Address ---	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4221 DUE TO (b) Arteriosclerosis, general Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH ? Years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/21 , 19 66 to 2/26 , 19 66 , that (I) (we) last saw the deceased alive on 2/26 , 19 66 , and that death occurred at 6:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE V. Juerman		22b. DATE SIGNED 2/28/66	
22c. PHYSICIAN'S NAME (Type) V. Juerman, M.D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 3-1-66	23c. NAME OF CEMETERY OR CREMATORY Green Acres	23d. LOCATION (City, town or county) (State) Salisbury Md
24. FUNERAL DIRECTOR Brooklyn McCleskey		25a. REC'D BY REGISTRAR MAR 3 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

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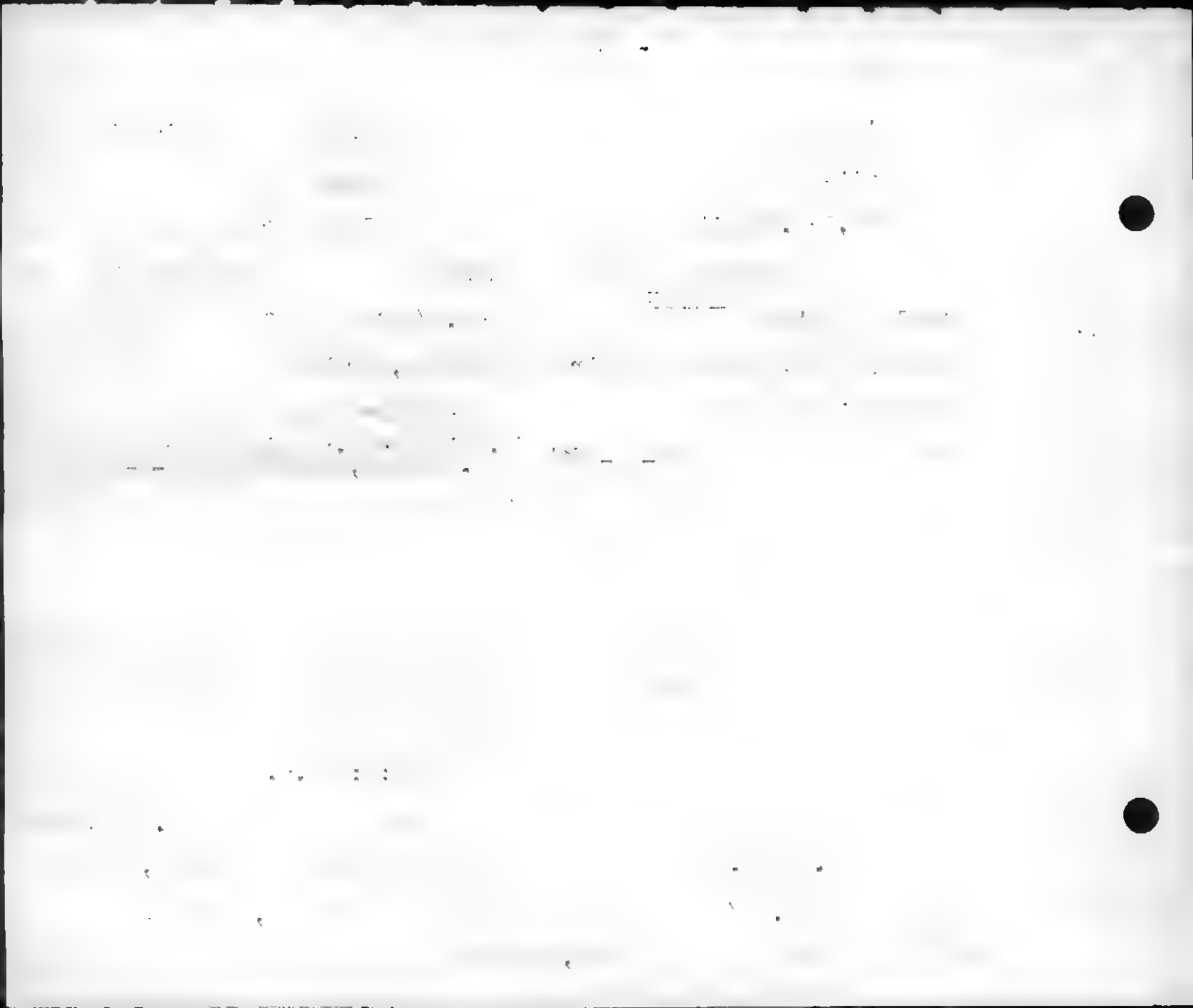
see

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hebron					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pen.Gen.Hospital				d. STREET ADDRESS Walnut Street					
3. NAME OF DECEASED (Type or print) First ELNORA Middle ELLEN Last HOPKINS				4. DATE OF DEATH Month FEBRUARY Day 10 Year 19 66					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 4/1892			
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 11 Days 8		IF UNDER 24 HRS. Hours Min. 					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery Store Owner - Retired				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (County & State, or foreign country) Hebron, Maryland			
12. CITIZEN OF WHAT COUNTRY? U S A									
13. FATHER'S NAME Henry Phippin				14. MOTHER'S MAIDEN NAME Josephine Humphreys					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 212-10-2694		17. INFORMANT Mr. Clifford J. Hopkins (Husband) Address Walnut St. Hebron, Maryland (PI-9-3903)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILIARY CIRRHOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 								INTERVAL BETWEEN ONSET AND DEATH 3 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 			
21. I certify that (I) (this hospital) attended the deceased from 1/13 , 19 66 , that (I) (we) last saw the deceased alive on 2/10 , 19 66 , and that death occurred at 11:25 p.m. , from the causes and on the date stated above.									
22a. SIGNATURE <i>John M. Bloxon</i> 22c. PHYSICIAN'S NAME (Type) Dr. John M. Bloxon				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. 22d. ADDRESS Medical Center Salisbury, Maryland		22b. DATE SIGNED Feb. 13/1966			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 13/1966		23c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery		23d. LOCATION (City, town or county) (State) Hebron, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR FEB 15 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

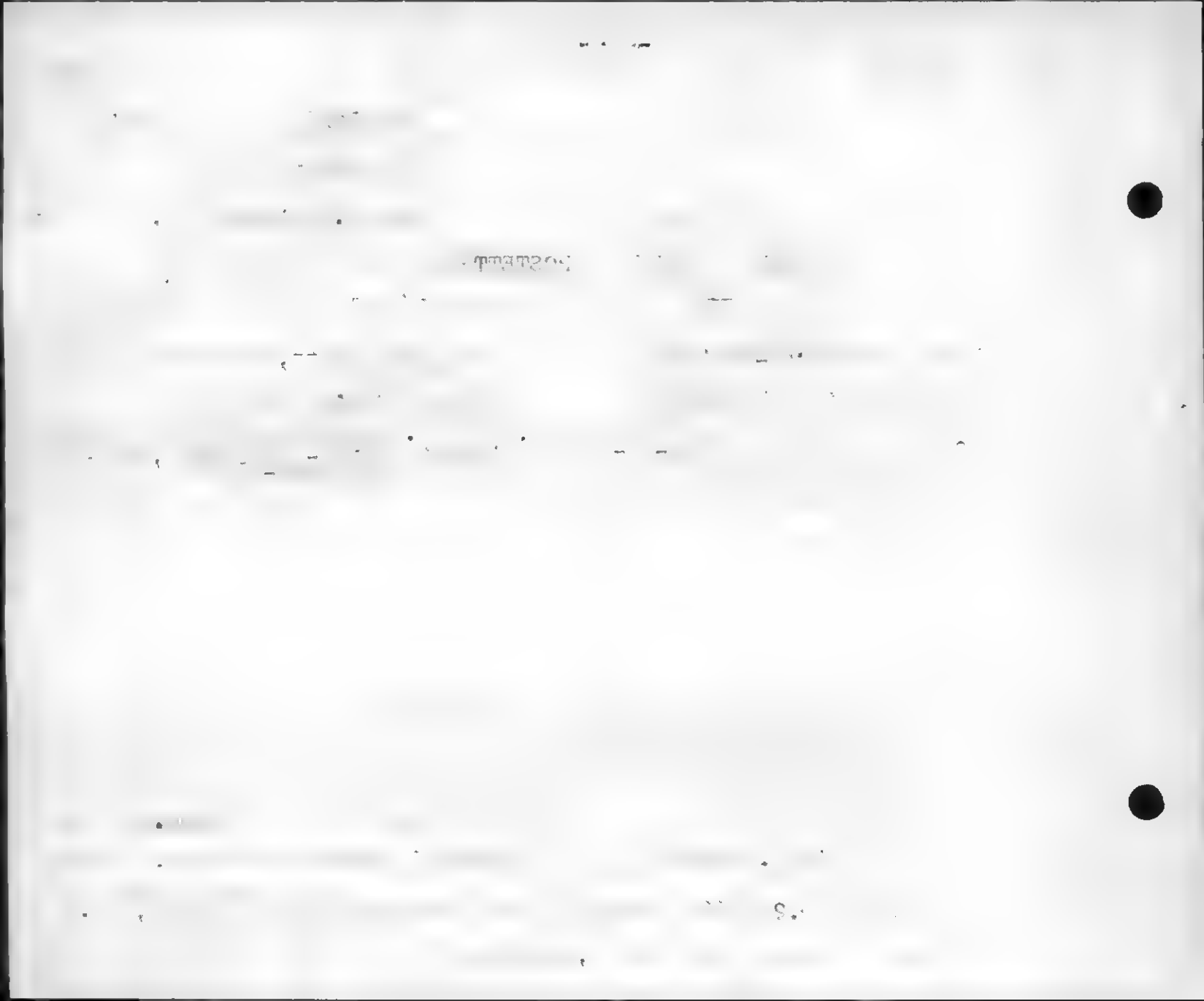
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return page 3 to the funeral director, who should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sumner's General Hospital</u>					d. STREET ADDRESS <u>301 N. Clairmont Dr.</u>				
3. NAME OF DECEASED (Type or print) <u>MARY RUTH HOSTETTER</u>					4. DATE OF DEATH <u>Feb. 28</u> 19 <u>66</u>				
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>June 15/1901</u> 9. AGE (In years last birthday) <u>64</u> yrs. <u>8</u> months <u>13</u> days				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Legal Secretary-Retired</u>					11. BIRTHPLACE (County & State, or foreign country) <u>Somerset County, Maryland U S A</u>				
13. FATHER'S NAME <u>William Major Whitehead</u>					14. MOTHER'S MAIDEN NAME <u>Susan Harriet Aydelotte</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>214-10-8760</u>				
					17. INFORMANT <u>Mr. Harry B. Hostetter (Husband)</u> Address <u>301 North Clairmont Drive - Salisbury, Md (2-2512)</u> Zip code <u>21801</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chemia</u> <u>592X</u> DUE TO (b) <u>Chronic Glomerulonephritis</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>approx 2 yrs</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>					20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 9</u> , 19 <u>66</u> , to <u>Feb 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 28</u> , 19 <u>66</u> , and that death occurred at <u>6:30</u> PM, from the causes and on the date stated above.									
22a. SIGNATURE <u>David J. Gilmore</u>					22b. DATE SIGNED <u>Feb. 28/1966</u>				
22c. PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>					22d. ADDRESS <u>Medical Center Salisbury, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Mar. 3/1966</u>					23b. DATE THEREOF				
23c. NAME OF CEMETERY OR CREMATORY <u>Virginia Line Cemetery</u>					23d. LOCATION (City, town or county) (State) <u>(Near New Church) Accomac County, Va.</u>				
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY SALISBURY, MARYLAND</u>					25a. REC'D BY REGISTRAR <u>Feb 27 1966</u> 25b. REGISTRAR'S SIGNATURE				



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

M

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02988

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c LENGTH OF STAY in 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Donald Lee Roberts HUTTON		4 DATE OF DEATH 2-19-66	
5. SEX M	6 COLOR OR RACE C	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 1-6-1955
9 AGE (In years last birthday) 11 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life even if not regular) None		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) MARYLAND		12 CITIZEN OF WHAT COUNTRY USA	
13 FATHER'S NAME Clifton Hutton		14 MOTHER'S MAIDEN NAME Anna Brown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO	
17 INFORMANT Hospital Records Salisbury, Md		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Strangulation DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden Sudden	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Playing with rope in tree and hanged himself.	
20c TIME OF INJURY Month Day, Year 3:50 P.M. 2-19-66		20d INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Wooded area.	
20e PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) Sharptown Wicomico Md.		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED 2-21-66	
EXAMINER'S NAME (Type) 109 Camden Ave. Salisbury, Md.		Address (Street city town, or county)	
23a B. BURIAL, CREMATION, REMOVAL (Specify)		23b DATE THEREOF 2-23-66	
23c NAME OF CEMETERY OR CREMATORY Sharptown, Md.		23d LOCATION (City or Town) (County) (State) Wicomico Md.	
24 FUNERAL DIRECTOR James B. Washell		25a REC'D BY REGISTRAR FEB 24 1966	
ADDRESS Easton Md.		25b REGISTRAR'S SIGNATURE Charles Judge	



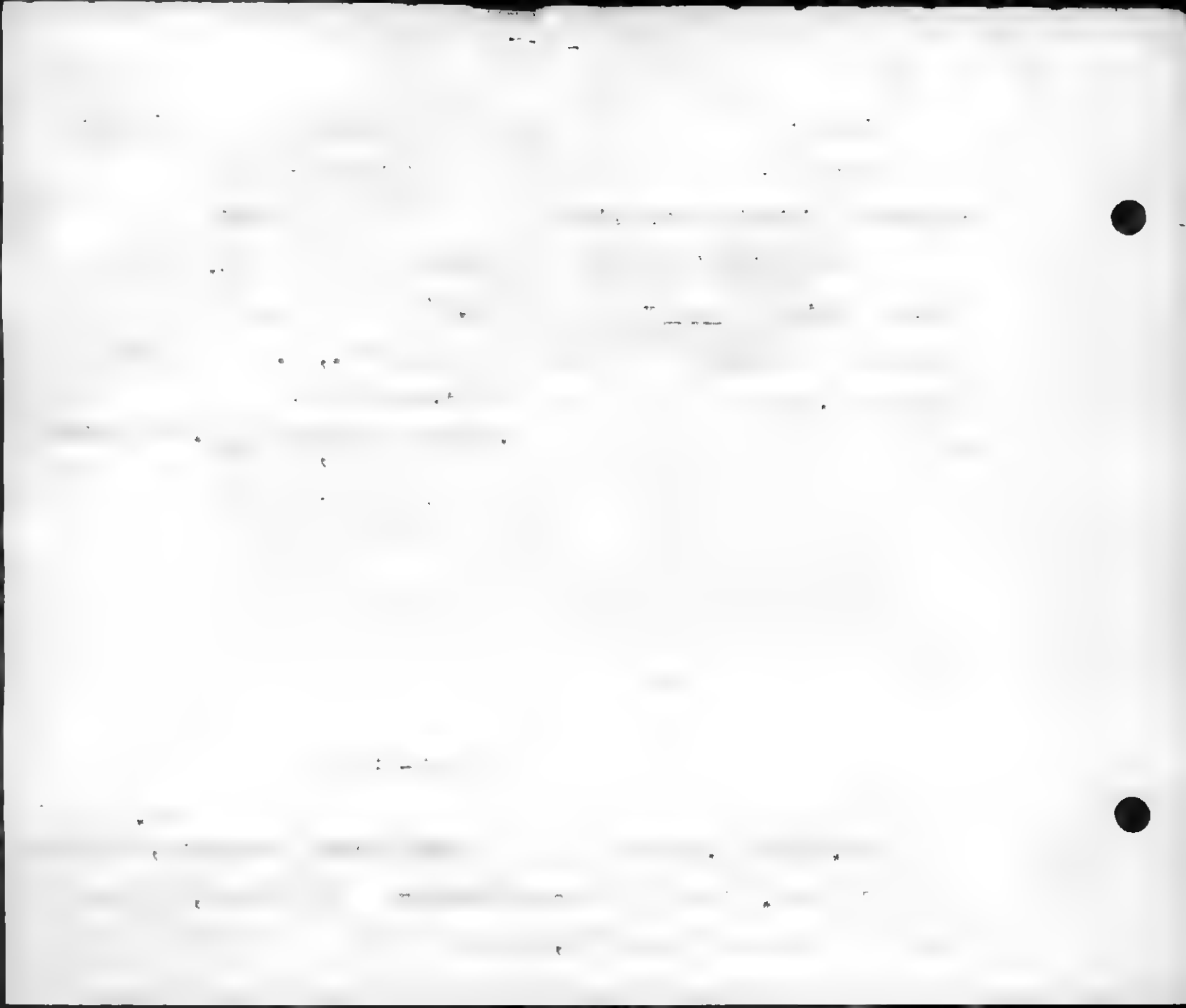
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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
033003 CERTIFICATE OF DEATH 02989

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springhill Private Sanitarium		d. STREET ADDRESS 305 Park Avenue	
3. NAME OF DECEASED (Type or print) MARY SUSAN (MOLLIE)		4. DATE OF DEATH FEB. 28th 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6/1880
9. AGE (in years last birthday) 86 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife at home		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Accomac Co., Va.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Johannas L. Byrd		14. MOTHER'S MAIDEN NAME Elizabeth Parks	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT L. Kerns Mears (Son)		18. ADDRESS 734 S. Park Drive Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac decompensation 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Open selective heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic pancreatitis			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from AUGUST 1951 to FEB. 28, 1966 , that (I) (we) last saw the deceased alive on 27, 1966 , and that death occurred at ADD-5:40P M, from the causes and on the date stated above.			
22a. SIGNATURE Philip A. Insley			22b. DATE SIGNED Mar. 2/1966
22c. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley			22d. ADDRESS Main Street Salisbury, Maryland
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar. 3/1966	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery
23d. LOCATION (City, town or county) (State) Salisbury, Maryland		24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY, MARYLAND	
25a. REC'D BY REGISTRAR 7 1966		25b. REGISTRAR'S SIGNATURE Philip A. Insley	



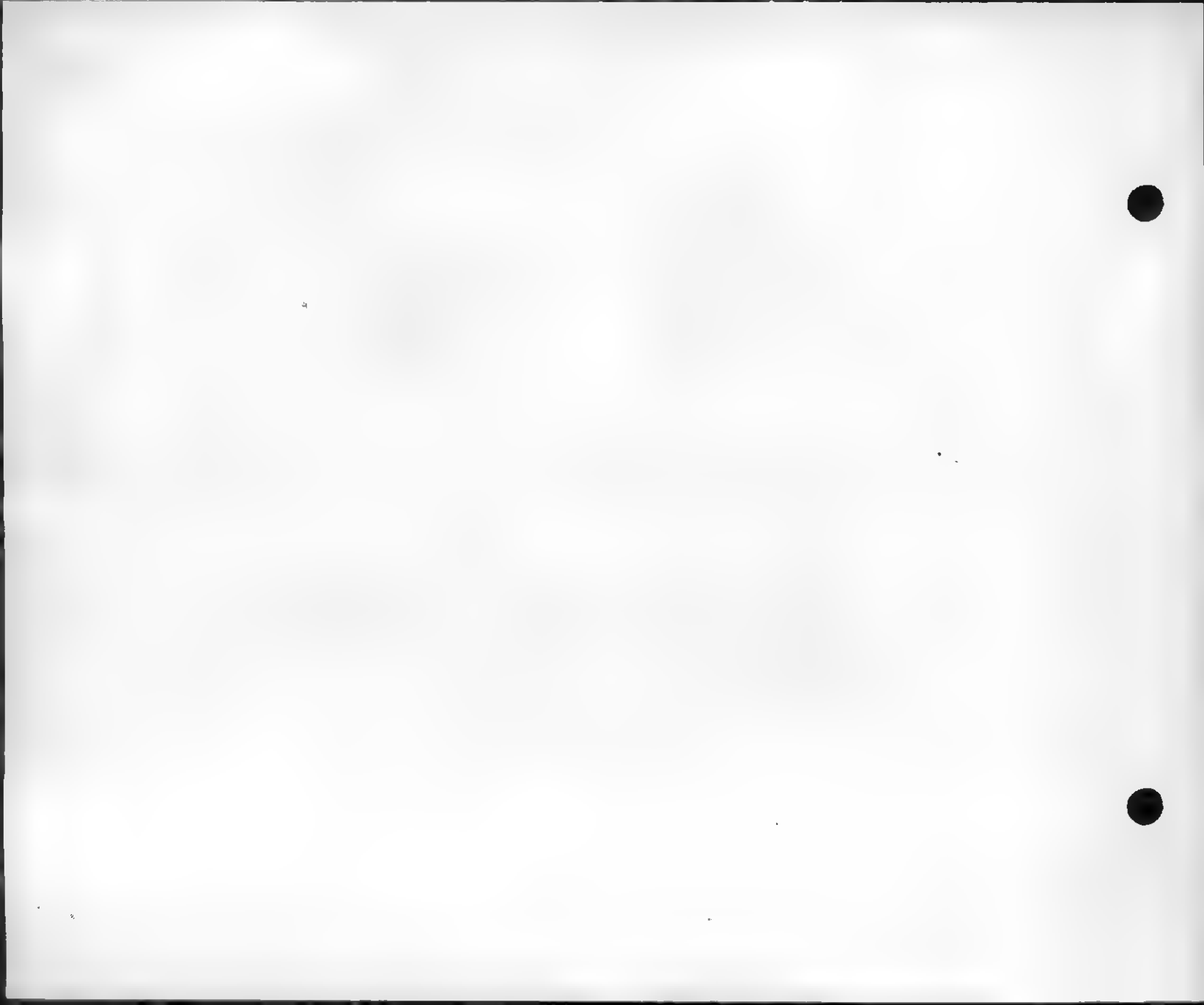
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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Worcester</u> <u>Stockton</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kenansula General Hospital</u>					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) First <u>Adaline</u> Middle <u>P.</u> Last <u>Johnson</u>					4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 6, 1887</u>		9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Accomack, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>BENJAMIN T. F. PARKS</u>					14. MOTHER'S MAIDEN NAME <u>ELLA WATTS</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>230-14-8184 MAS</u>		17. INFORMANT <u>Luther Towitt Jr., Stockton, Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 11, 1966</u> to <u>Feb. 19, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb. 19, 1966</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>David J. Lawrence</u>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/21/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parksley</u>		23d. LOCATION (City, town or county) (State) <u>Parksley, VA.</u>			
24. FUNERAL DIRECTOR <u>Henry M. Johnson</u>					25a. REC'D BY REGISTRAR <u>2/21/66</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

FEB 23 1966



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u> d. STREET ADDRESS <u>Box 44</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EMMA IRENE Johnson</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>August 19, 1932</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>33</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			4. DATE OF DEATH <u>February 21, 1966</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>John Johnson</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Clarissa Dashiell</u> 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Leonard Johnson</u> Address <u>Quantico Box 44</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>447x</u> DUE TO <u>Hypertensive Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral hemorrhage</u> DUE TO (c) <u>cerebral</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>1/27/66</u>			
20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Md.</u>		21. I certify that (I) (this hospital) attended the deceased from <u>2-21</u> , 19 <u>66</u> to <u>2-25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-21</u> , 19 <u>66</u> and that death occurred at <u>2:42</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>Wilber R. Ellis, Jr.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>2-23-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Wilber R. Ellis, Jr., M.D.</u>				22d. ADDRESS <u>Medical Center, Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/25/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Church</u>			
23d. LOCATION (City, town or county) <u>Quantico</u> (State) <u>Md.</u>		24. FUNERAL DIRECTOR <u>Clinton F. Stewart</u> ADDRESS <u>Salisbury Md.</u>					
25a. REC'D BY REGISTRAR <u>FEB 28 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove portion papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
03006 CERTIFICATE OF DEATH 02992									
Item #2 c & d info. taken from birth cert.									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN lb <u>1 week</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>421 Keene Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Jones</u> Middle <u>Jones</u> Last <u>Jones</u>			4. DATE OF DEATH Month <u>February</u> Day <u>11</u> Year <u>1966</u>			9. AGE (In years last birthday) <u>1</u> IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 10, 1966</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury Maryland</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Calvin Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Calvin Jones</u> Address <u>Salisbury</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity 800 gms</u> 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>776X</u> DUE TO (c) <u>776X</u>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/10</u> , 19 <u>66</u> , to <u>2/11</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/11</u> , 19 <u>66</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>William C. Morgan</u>						22b. DATE SIGNED <u>2/11/66</u>		22c. PHYSICIAN'S NAME (Type) <u>William C. Morgan</u>	
22d. ADDRESS						22e. REC'D BY REGISTRAR			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<u>Burial</u>		<u>2-13-66</u>		<u>Green Acres</u>		<u>Salisbury Md</u>			
24. FUNERAL DIRECTOR <u>Booker M. West</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	
DATE <u>FEB 16 1966</u>									

6-196608



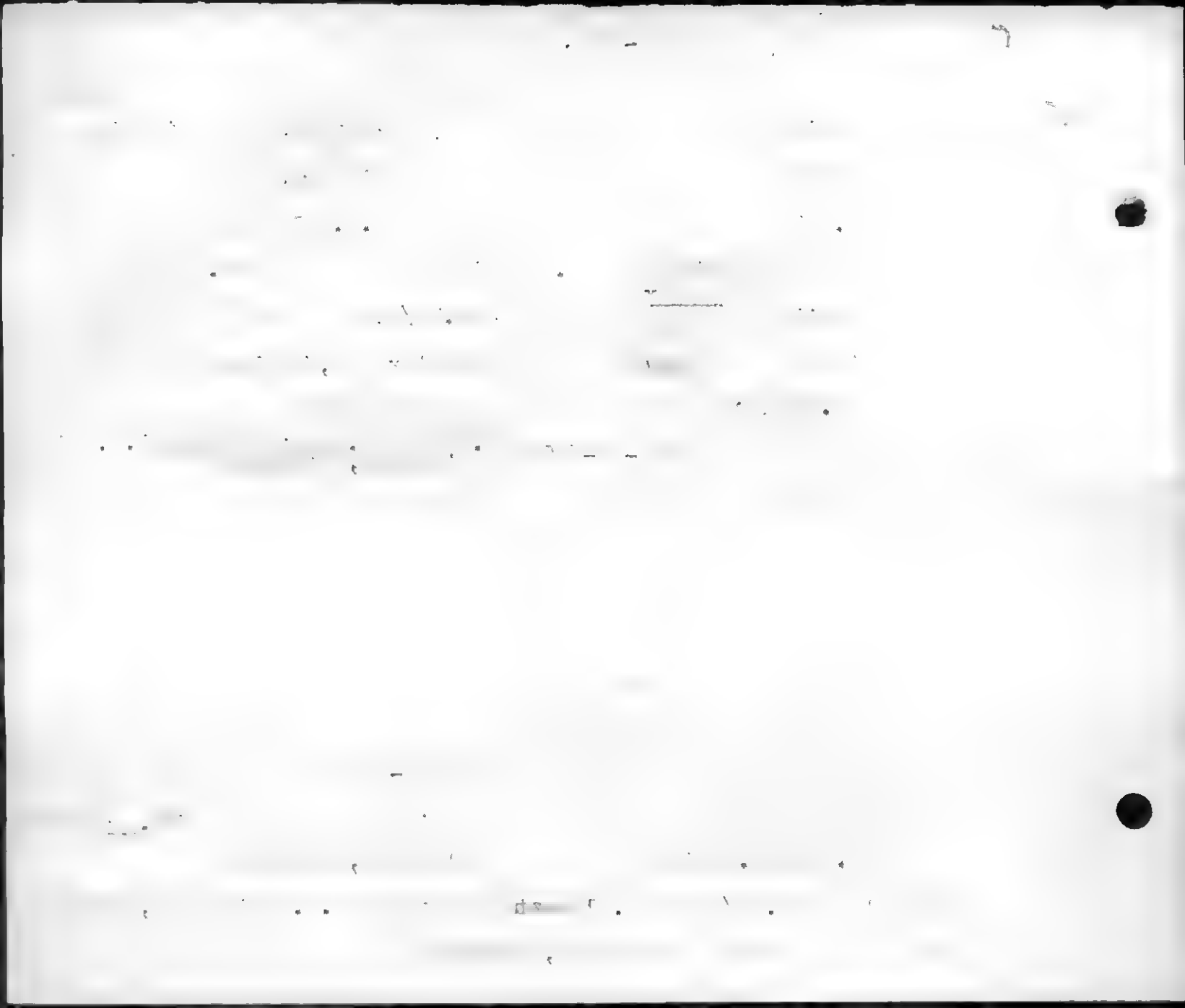
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

03007

02993

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Willards c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.D.# 1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Willards d. STREET ADDRESS R.D.# 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle E. Last JONES		4. DATE OF DEATH Month FEB. Day 24 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 12/1892
9. AGE (In years last birthday) 74		10. IF UNDER 1 YEAR Months 1 Days 12	11. IF UNDER 24 HRS. Hours 12 Min. 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Powellville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles H. Bethard		14. MOTHER'S MAIDEN NAME Sallie Calla	
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-36-5502	
17. INFORMANT Mr. Ernest T. Jones (Husband)		Address R.D.# 1 Willards, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 143X DUE TO (b) Hypertension DUE TO (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 , 19 2-24 , 1966, that (I) (we) last saw the deceased alive on 2-24 , 1966, and that death occurred at 7 A AM, from the causes and on the date stated above.			
22a. SIGNATURE Frank Lewis		22b. DATE SIGNED Feb. 28/1966	
22c. PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis		22d. ADDRESS Willards, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 27/1966	
23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		23d. LOCATION (City, town or county) (State) R.D.# Willards, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	
25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2-2-66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03283
CERTIFICATE OF DEATH
12994

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Elsie</u> Middle <u>Jones</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>February</u> Day <u>16</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 4, 1894</u> 9. AGE (in years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR Months <u>8</u> Days <u>14</u> Hours <u>14</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VENTON MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY BYRD</u>		14. MOTHER'S MAIDEN NAME <u>MARY CARR</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-080175</u> 17. INFORMANT <u>Charles Jones Princess Anne Md</u> Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>CVA Brain Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension C.V. Disease</u> (c) <u>Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>Weak</u> <u>club</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes - Renal Insufficiency</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 15, 1965</u> to <u>Feb 16, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 16, 1966</u> , and that death occurred at <u>7:35 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Herbert Sembly</u> M.D.		22b. DATE SIGNED <u>Feb 17, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Herbert Sembly</u>		22d. ADDRESS <u>Salisbury Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Feb 20, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GRACE</u>	23d. LOCATION (City, town or county) (State) <u>VENTON, SOM, MD</u>
24. FUNERAL DIRECTOR <u>Charles Howard, Marion</u> ADDRESS <u>md</u>		25a. REC'D BY REGISTRAR <u>Feb 23 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

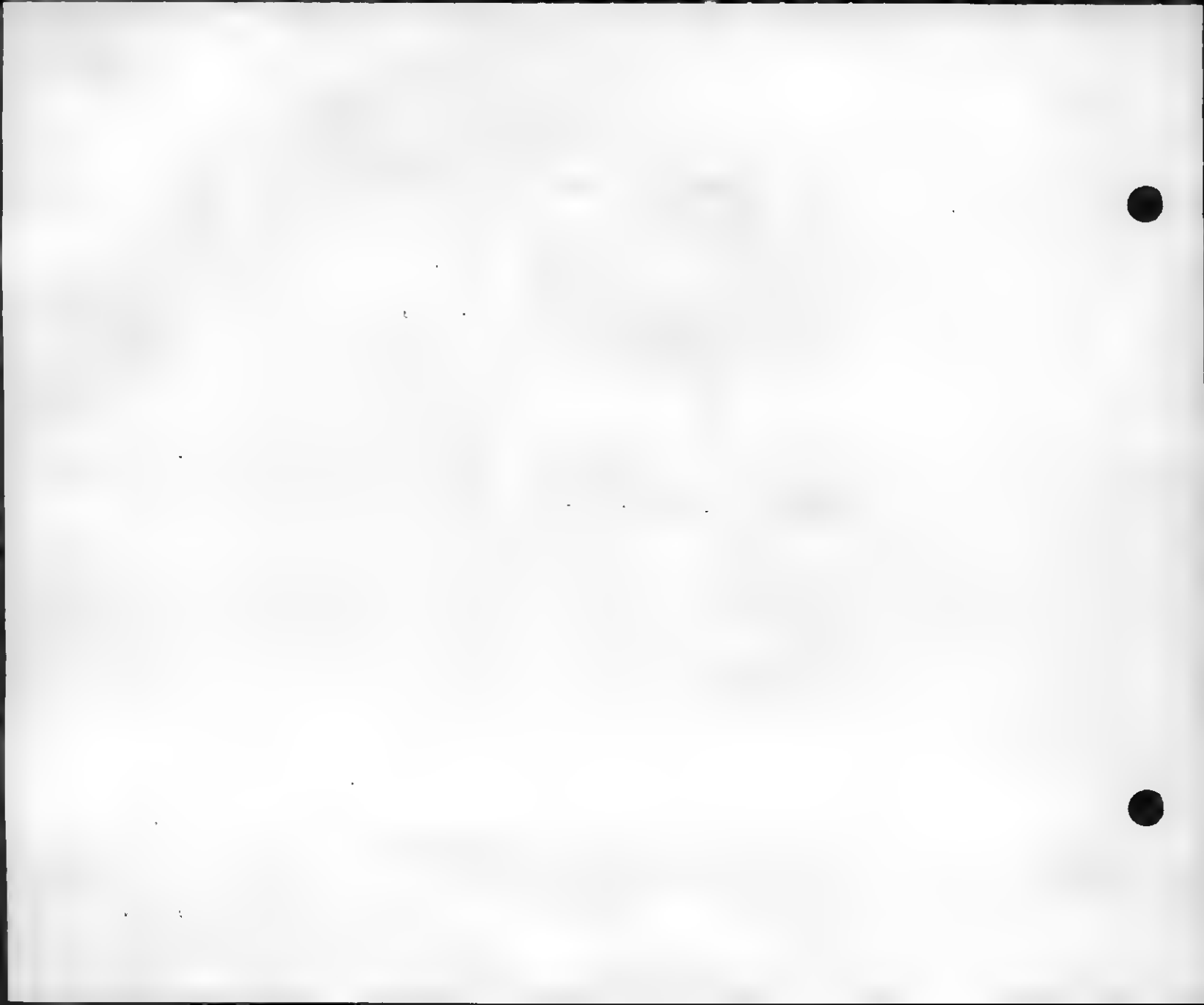
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03003

CERTIFICATE OF DEATH

02995

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Suxsex</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Roxana</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pinnasula General Hospital</u>				d. STREET ADDRESS <u>Frankford, Del. R.F.D.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Emma Elizabeth Jones</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>16</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 14, 1897</u>	9. AGE (in years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>16</u> Days <u>19</u> Hours <u>66</u> Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Peter West</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Hudson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u>		16. SOCIAL SECURITY NO. <u>XX</u>		17. INFORMANT <u>Ebe Jones Frankford, Del. RFD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage.</u> DUE TO (b) <u>Subarachnoid Hemorrhage.</u> DUE TO (c) <u>A S C V D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-15</u> , 19 <u>66</u> , to <u>2-16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-16</u> , 19 <u>66</u> , and that death occurred at <u>7:18</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>				22b. DATE SIGNED <u>2/16/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Medical Center Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/18/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dale</u>		23d. LOCATION (City, town or county) (State) <u>Whaleyville, Md.</u>	
24. FUNERAL DIRECTOR <u>Peter Whaley Salisbury, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

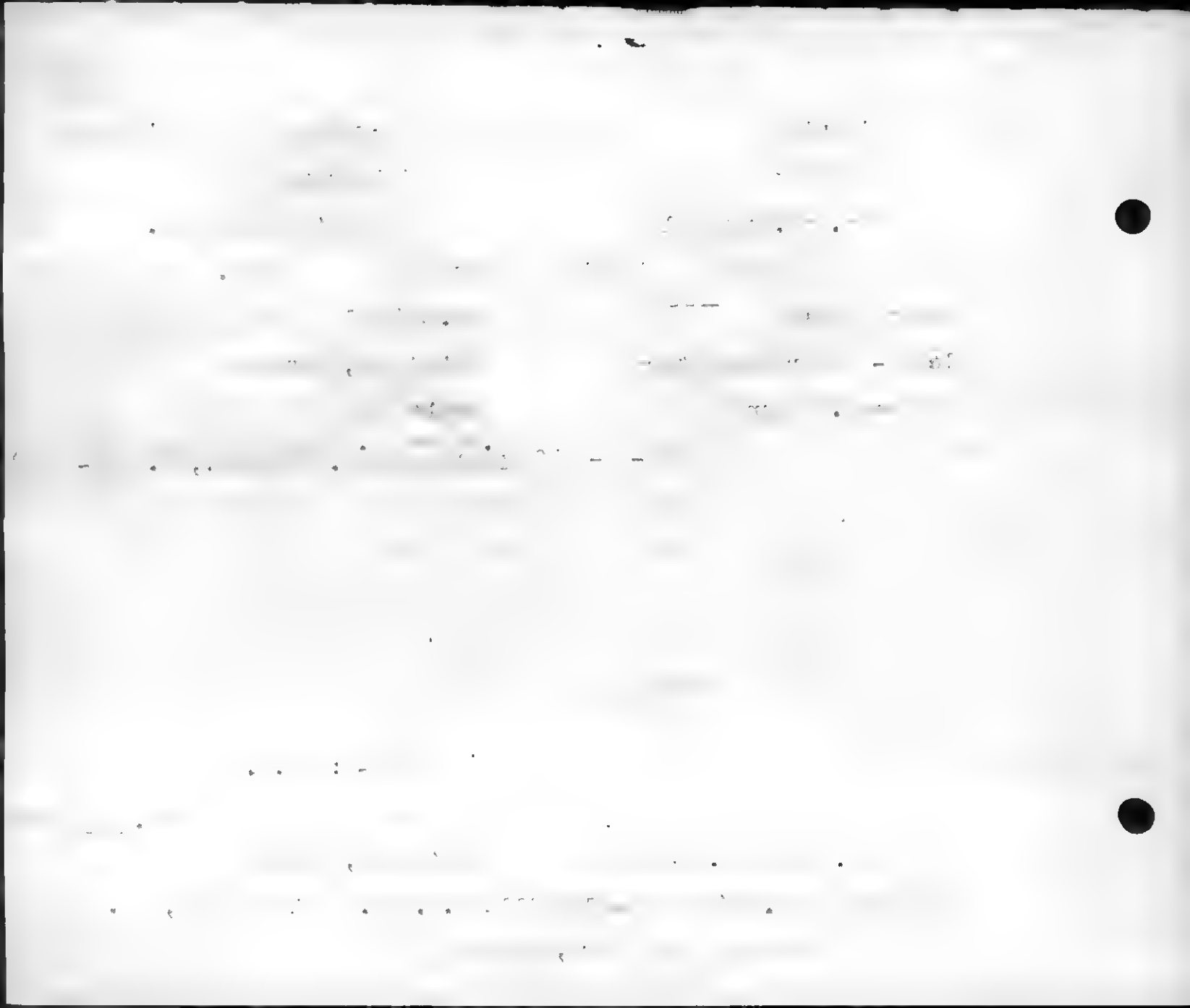


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pen.Gen.Hospital		d. STREET ADDRESS 1107 Middleneck Dr.	
3. NAME OF DECEASED (Type or print) AGNES LILLIAN KENNEDY		4. DATE OF DEATH Month FEB. Day 25 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar.28/1901
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 10 Days 27 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clark - Department store		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (County & State, or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William D.Nelson		14. MOTHER'S MAIDEN NAME Anna Belle Laird	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-28-8010	
17. INFORMANT Mr. Warren R. Kennedy (Husband)		Address 1107 Middleneck Dr. Salisbury, Md. (PI 9-7573)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis & asystole 4:20 P DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Congestive Heart Failure 2) H.T. hemorrhage, ? site INTERVAL BETWEEN ONSET AND DEATH 2 years INSTANT			
20a. ACCIDENT OR UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 19 60 to Feb 25 19 66 , that (II) (we) last saw the deceased alive on Feb 25 1966 , and that death occurred at App-1:00P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert T. Adkins		22b. DATE SIGNED Feb. 26/1966	
22c. PHYSICIAN'S NAME (Type) DR. Robert T. Adkins		22d. ADDRESS Fruitland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb.28/1966	23c. NAME OF CEMETERY OR CREMATORY Kamblesville M.F.Cem.	23d. LOCATION (City, town or county) (State) Kemblesville, Pa.
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR FEB 28 1966	
ADDRESS SALISBURY, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

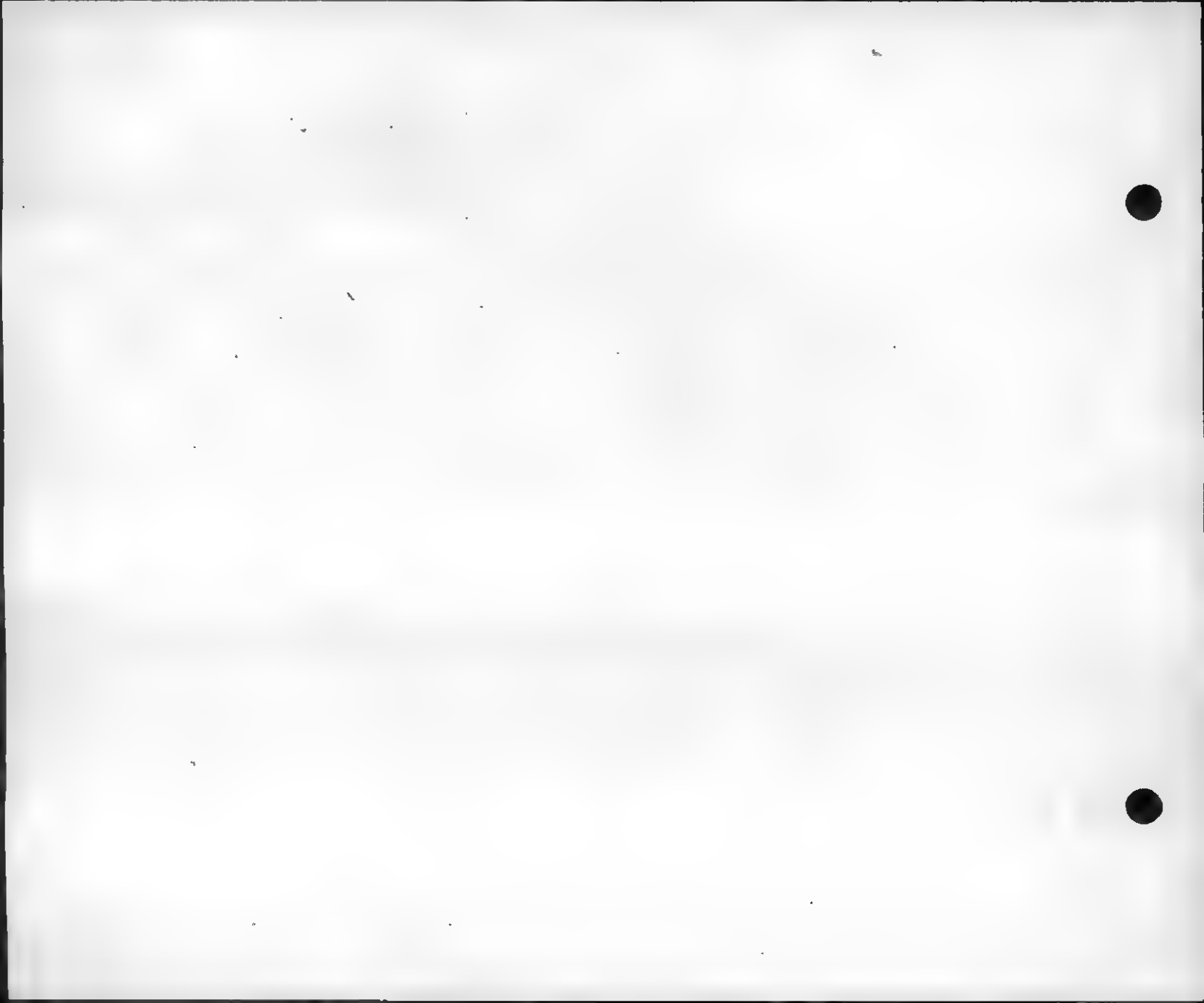
CERTIFICATE OF DEATH

12898

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 18 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY d. STREET ADDRESS 309 N. DIVISION e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mollie G. Lecates		4. DATE OF DEATH Month February Day 14 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-1897 9. AGE (in years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RT. CASHIER		10b. KIND OF BUSINESS OR INDUSTRY UTILITY	11. BIRTHPLACE (County & State, or foreign country) DELMAR - MD.
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME ELMER E. LECATES	
14. MOTHER'S MAIDEN NAME LAURA RUARK.		15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 214-10-6006		17. INFORMANT Elmer E. Lecates - Delmar, Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Bleeding Duodenal Ulcer, Staphylococcal Pyelonephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bleeding Duodenal Ulcer, Staphylococcal Pyelonephritis			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (the hospital) attended the deceased from Jan 27, 1966 to Feb 14, 1966 , that (I) (we) last saw the deceased alive on Feb 13, 1966 , and that death occurred at 12:45 AM , from the causes and on the date stated above.	
22a. SIGNATURE Thomas C. Hill Jr.		22b. DATE SIGNED 2/14/66	
22c. PHYSICIAN'S NAME (Type) Thomas C. Hill Jr.		22d. ADDRESS Pine Bluff Road, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-16-66	
23c. NAME OF CEMETERY OR CREMATORY St Stephens		23d. LOCATION (City, town or county) (State) Delmar Del.	
24. FUNERAL DIRECTOR Charles W. Garret - Delmar, Del.		25a. REC'D BY REGISTRAR FEB 16 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

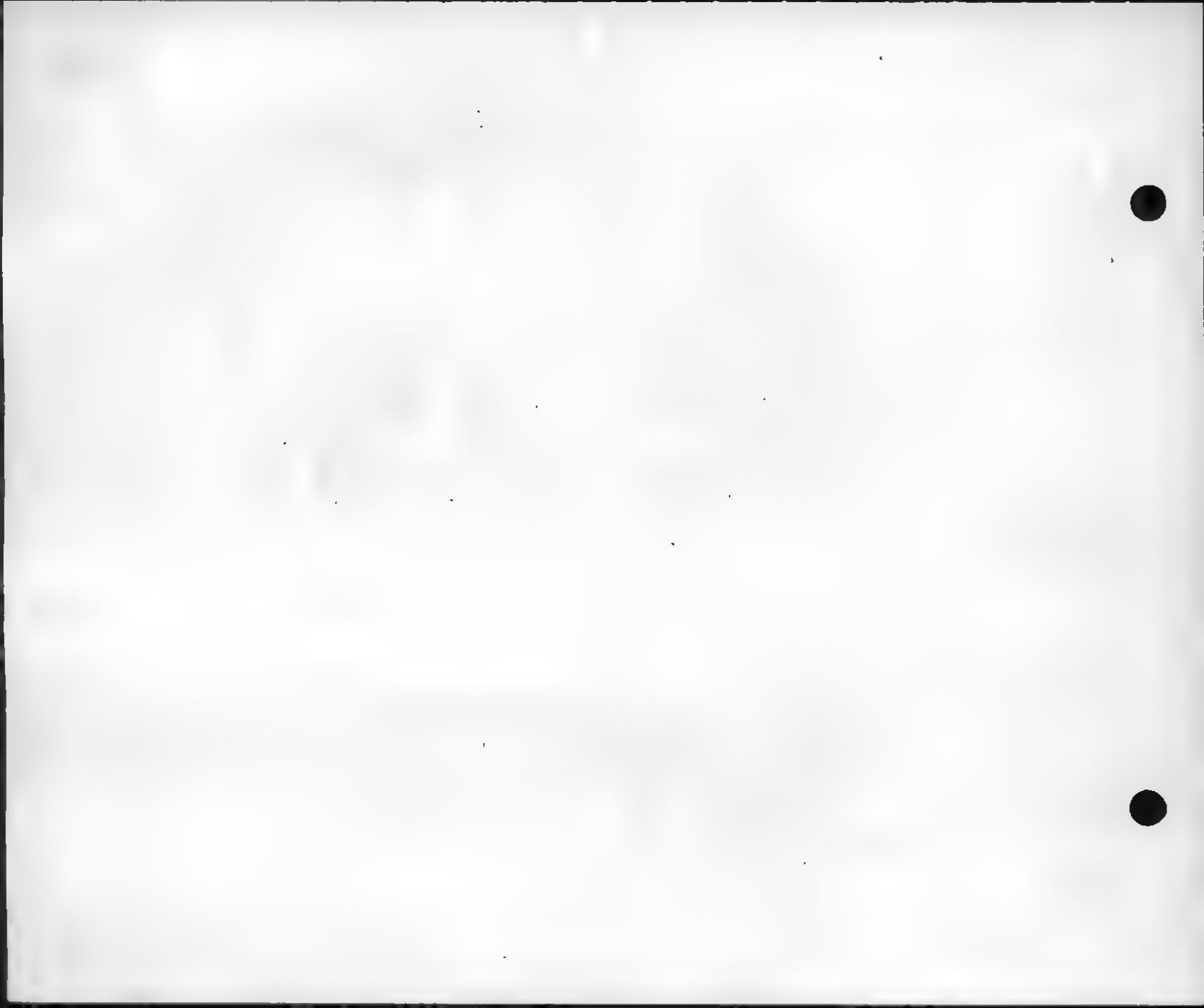
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN ID <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u> d. STREET ADDRESS <u>RT # 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>BERTIE ALICE MADDOX</u>			4. DATE OF DEATH <u>FEBRUARY 28 1966</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>DELMAR-DEL</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>SOUTHEY BRITTINGHAM</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>NORMA NICHOLS-DELMAR-MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exhaustion Myocardial Infarction</u> 4201 DUE TO (b) <u>Arteriosclerotic coronary heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>2/27/66</u> to <u>2/28/66</u> , that (I) (we) last saw the deceased alive on <u>2/27/66</u> and that death occurred at <u>8 PM</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>[Signature]</u>					22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		25a. REC'D BY REGISTRAR	
<u>BURIAL</u>			<u>3-3-66</u>		<u>ST STEPHENS</u>		<u>DELMAR-DEL</u>		<u>MAR 4 1966</u>	
24. FUNERAL DIRECTOR <u>Charles A. Garrel - Delmar, Del</u>					25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03900

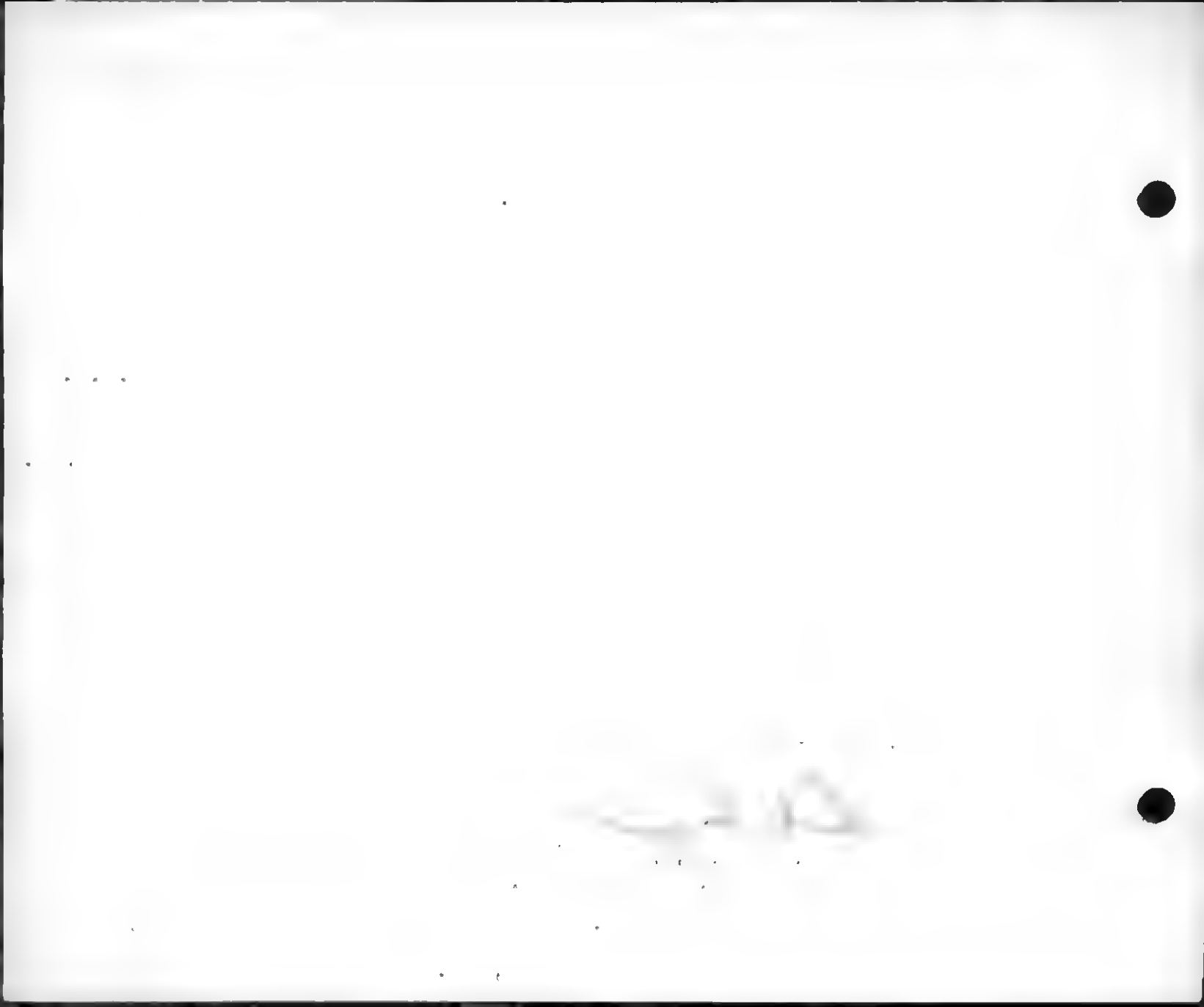
FOR STATE HEALTH DEPT

23013

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

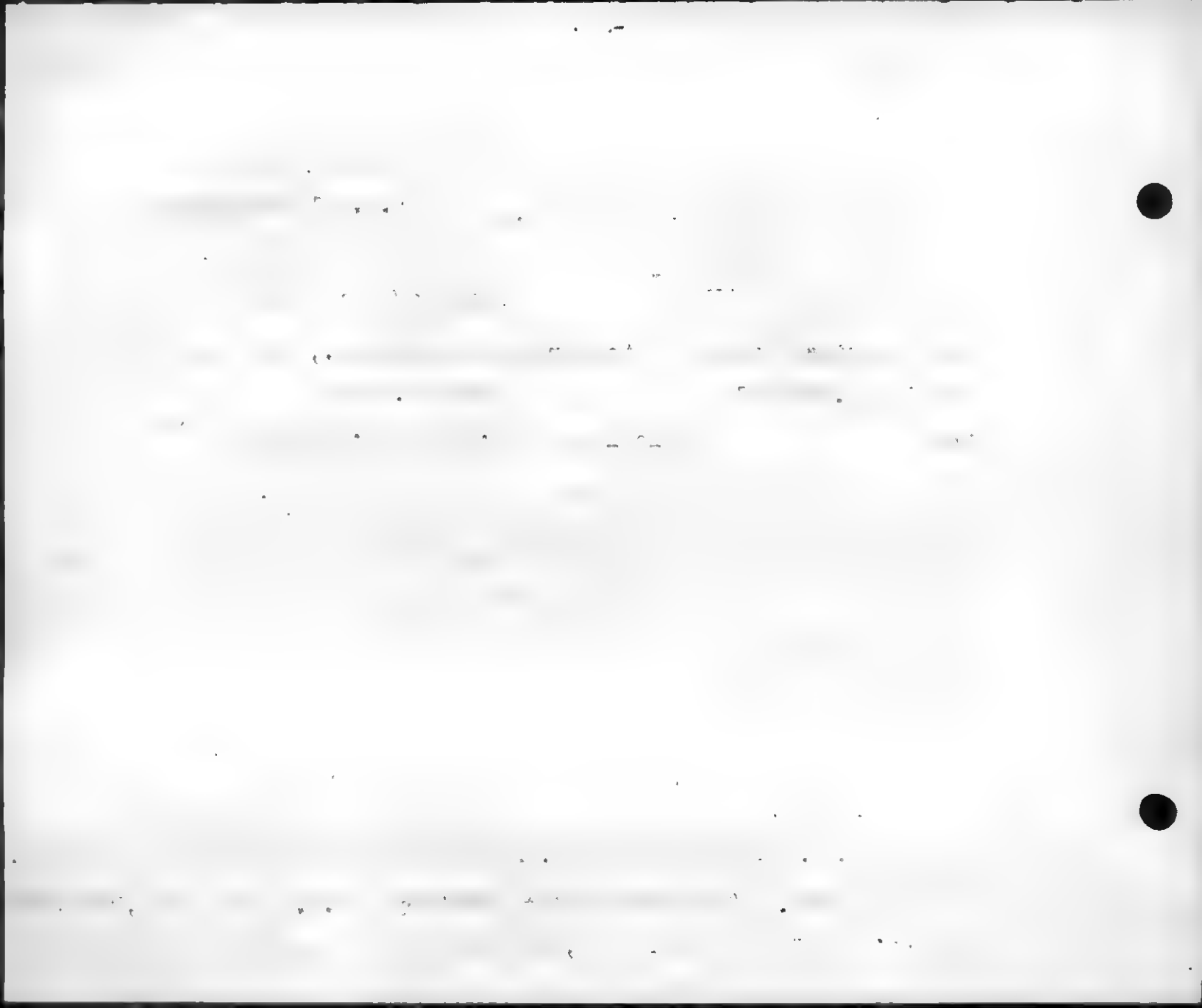
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS Route 2, Box 95			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3 NAME OF DECEASED (Type or print) CHARLES THOMAS MARSHALL First Middle Last				4 DATE OF DEATH 2-20-66 Month Day Year			
5 SEX M		6 CO. OR OR RACE C		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH 2-9-35	
9. AGE (in years lost birthday) 31 yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Collins				14. MOTHER'S M maiden name Lucinda Corbin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO 218 34 9515		17. INFORMANT Geraldine Marshall Address Stockton, Md.	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Asphyxia with pulmonary edema Y254 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Contused larynx with hemorrhage and edema DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Minutes 22 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Passenger in car involved in accident.			
20c. TIME OF INJURY Month, Day, Year 9:30 P.M. 2-19-66 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Highway	
				20f. (City or town) Oak Hall (County) Va. (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.				22. DATE SIGNED 2-24-66			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.				Address (Street, city, town, or county) 1409 Camden Ave., Salisbury, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/25/66		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope		23d. LOCATION (City or Town) Stockton, Md. (County) (State)	
24. FUNERAL DIRECTOR Edgar Wharton				ADDRESS New Church, Va.		25a. REC'D BY REGISTRAR FEB 28 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	



1
IN HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please prepare carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03014 CERTIFICATE OF DEATH 02001											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 63 days		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Route #1, Salisbury					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.						d. STREET ADDRESS R.D.# 1 Shad Point				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clifford Middle Penn Last Marshall			4. DATE OF DEATH Month February Day 9 Year 1966			5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH July 13/1901			9. AGE (In years last birthday) 64 yrs. 6 Months 26 Days Hours Min.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Service Manager Auto Garage Wicomico Co., Maryland		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop Service Manager Auto Garage Wicomico Co., Maryland			10b. KIND OF BUSINESS OR INDUSTRY U S A			11. BIRTHPLACE (County & State, or foreign country) U S A			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME William E. Marshall						14. MOTHER'S MAIDEN NAME Rona B. Jones					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. 218-05-8006					
17. INFORMANT Mrs. Esther A. Marshall (Wife) (Same as # 2 above)						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic carcinoma of left lung with metastasis to neck; and pulmonary atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease with coronary insufficiency (c) PART II. OTHER SIGNIF. COND. CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 											
INTERVAL BETWEEN ONSET AND DEATH Months Years											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)				20h. (City or town) (County) (State)			
21. I certify that (I) (th's hospital) attended the deceased from December 8, 1966 , to February 9, 1966 , that (I) (we) last saw the deceased alive on February 9, 1966 , and that death occurred at 8:15 AM , from the causes and on the date stated above.											
22a. SIGNATURE C. F. Gutierrez-Carrido M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED 2/9/66											
22c. PHYSICIAN'S NAME (Type) C. F. Gutierrez-Carrido, M.D. 22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Feb. 12/1966				23c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery			
23d. LOCATION (City, town or county) (State) R.D.# Salisbury, Maryland				24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR FEB 17 1966			
25b. REGISTRAR'S SIGNATURE J. Charles Judge											



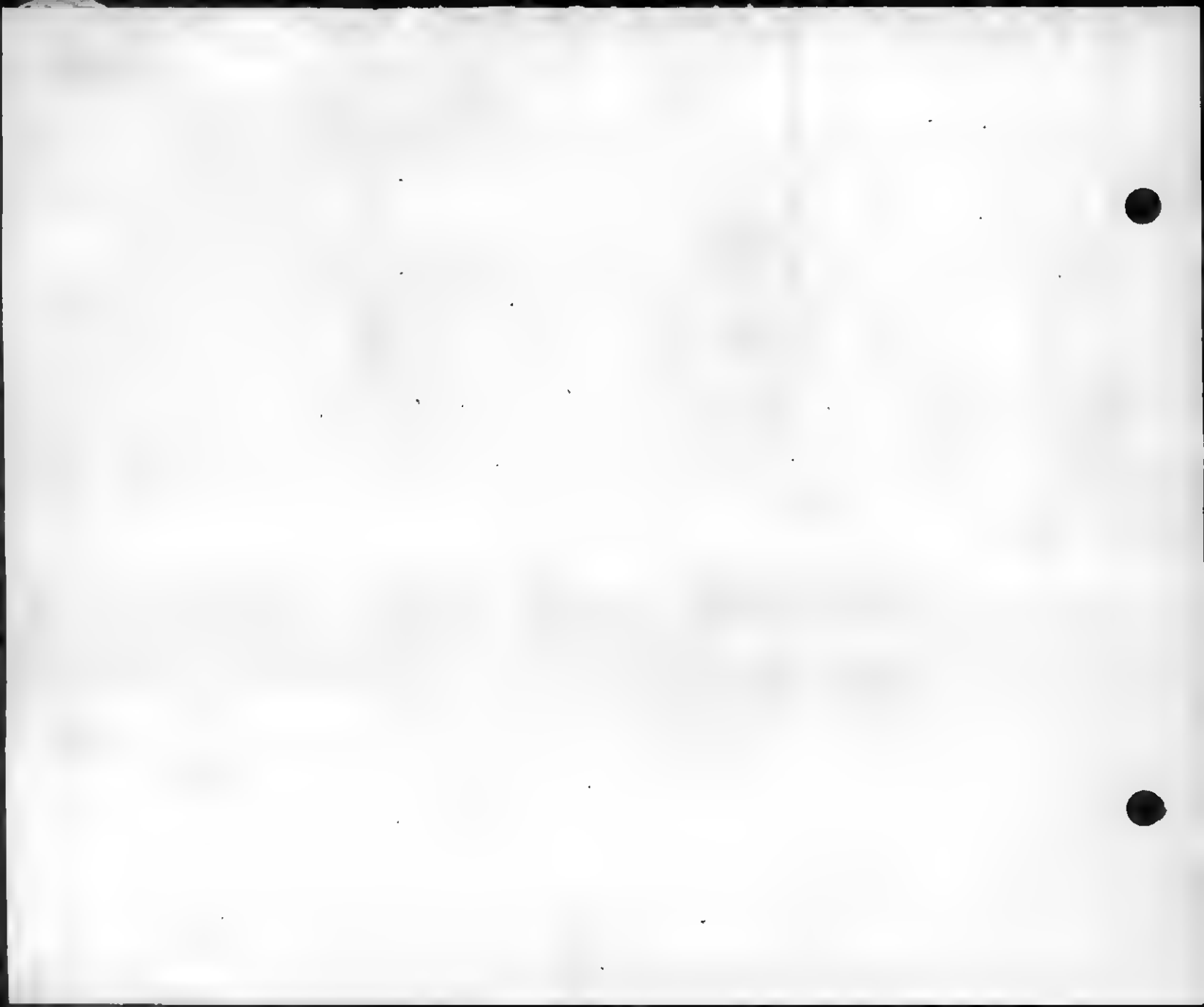
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03015 CERTIFICATE OF DEATH 02002

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>22-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General</u>				d. STREET ADDRESS <u>Box 210, Route 2</u>			
3. NAME OF DECEASED (Type or print) <u>Katherine Matthews</u>				4. DATE OF DEATH <u>February 26 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 10, 1927</u>	
9. AGE (in years last birthday) <u>38</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>			
13. FATHER'S NAME <u>Edward Waters</u>				14. MOTHER'S MAIDEN NAME <u>Katie Wilson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Orlando Matthews</u>				Address <u>Pocomoke City, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma large bowel</u> <u>1058</u> DUE TO <u>2 multiple melanomas.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/3/66</u> to <u>2/26/66</u> , that (I) (we) last saw the deceased alive on <u>2/25/66</u> , and that death occurred at <u>3:54 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3-3-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Unionville Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Pocomoke City, Md.</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please take the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03016

03003

1. PLACE OF DEATH
a. COUNTY

Wicomico

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

c. LENGTH OF STAY IN 1b

Since 7/6/65

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Pine Bluff State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE

Maryland

b. COUNTY

Wicomico

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

d. STREET ADDRESS

Spring Hill Road

e. RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED ☐ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday)

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS. Hours Min.

Male

White

WIDOWED ☒ DIVORCED ☐

Oct. 13, 1874

91 yrs.

Feb.

28

19

1966

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

11. BIRTHPLACE (County & State or foreign country)

Dagsboro, Delaware

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Isaac Matthews

Sally Hearne

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)

No

16. SOCIAL SECURITY NO.

221-09-8818 A

17. INFORMANT

Address

Unknown

Records of Pine Bluff State Hospital

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Pulmonary Tuberculosis

INTERVAL BETWEEN ONSET AND DEATH

Unknown

CONDITIONS, if any, which gave rise to immediate cause (e), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.

20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
While at work ☐ Not While at work ☐

20f. (City or town) (County) (State)

21. I certify that (this hospital) attended the deceased from July 6, 1965 to Feb. 28, 1966 that (we) last saw the deceased alive on Feb. 28, 1966, and that death occurred 1:30 PM, from the causes and on the date stated above.

22a. SIGNATURE

E. P. Ritchings

M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED

Feb. 28, 1966

22c. PHYSICIAN'S NAME (Type)

E. P. Ritchings

22d. ADDRESS

Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

3-3-66

23c. NAME OF CEMETERY OR CREMATORY

St Stephens

23d. LOCATION (City, town or county)

Delmar, Del.

24. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Marvil Funeral Home

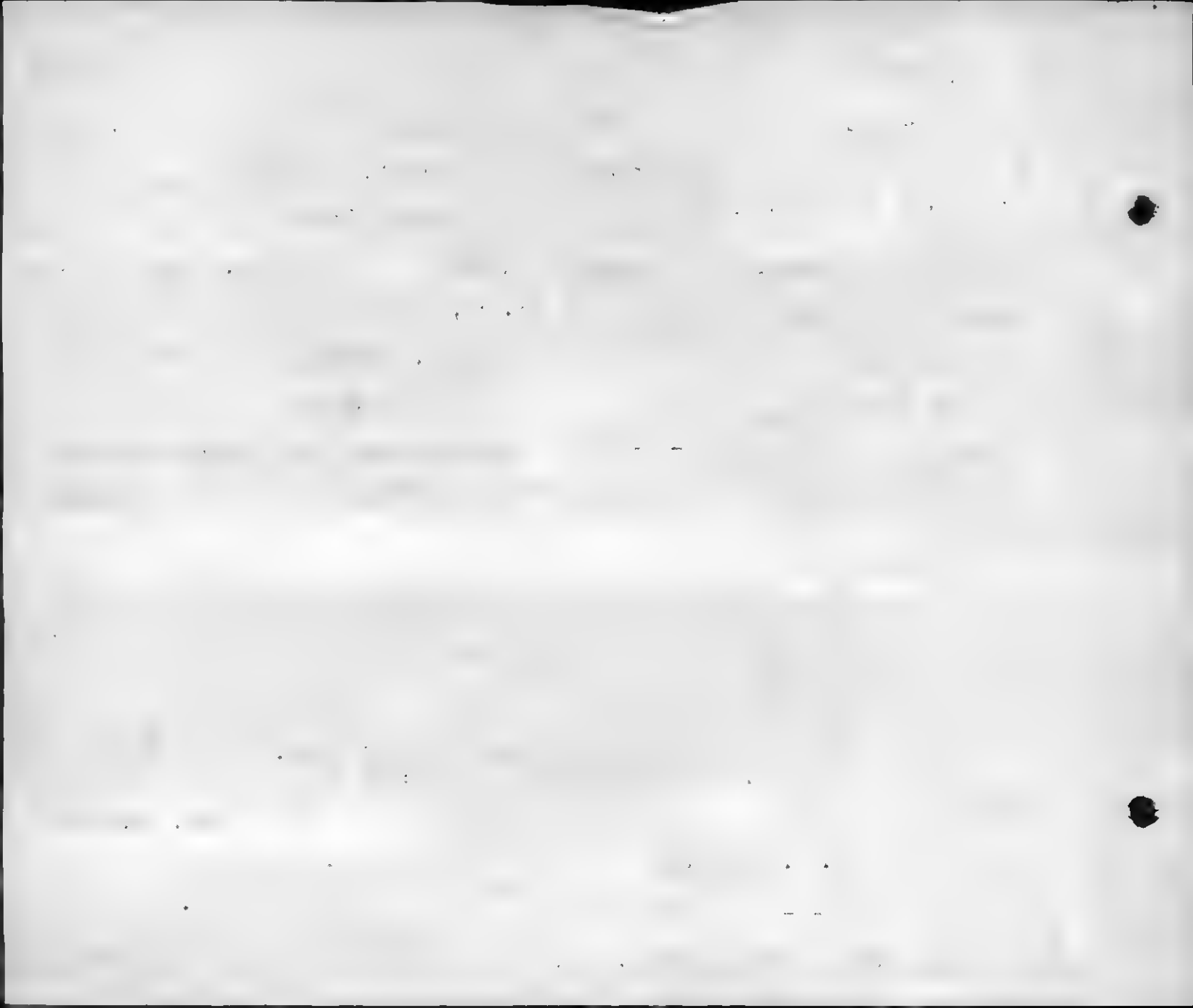
Delmar, Del.

25a. REC'D BY REGISTRAR

MAR 3 1966

25b. REGISTRAR'S SIGNATURE

Charles Judge



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

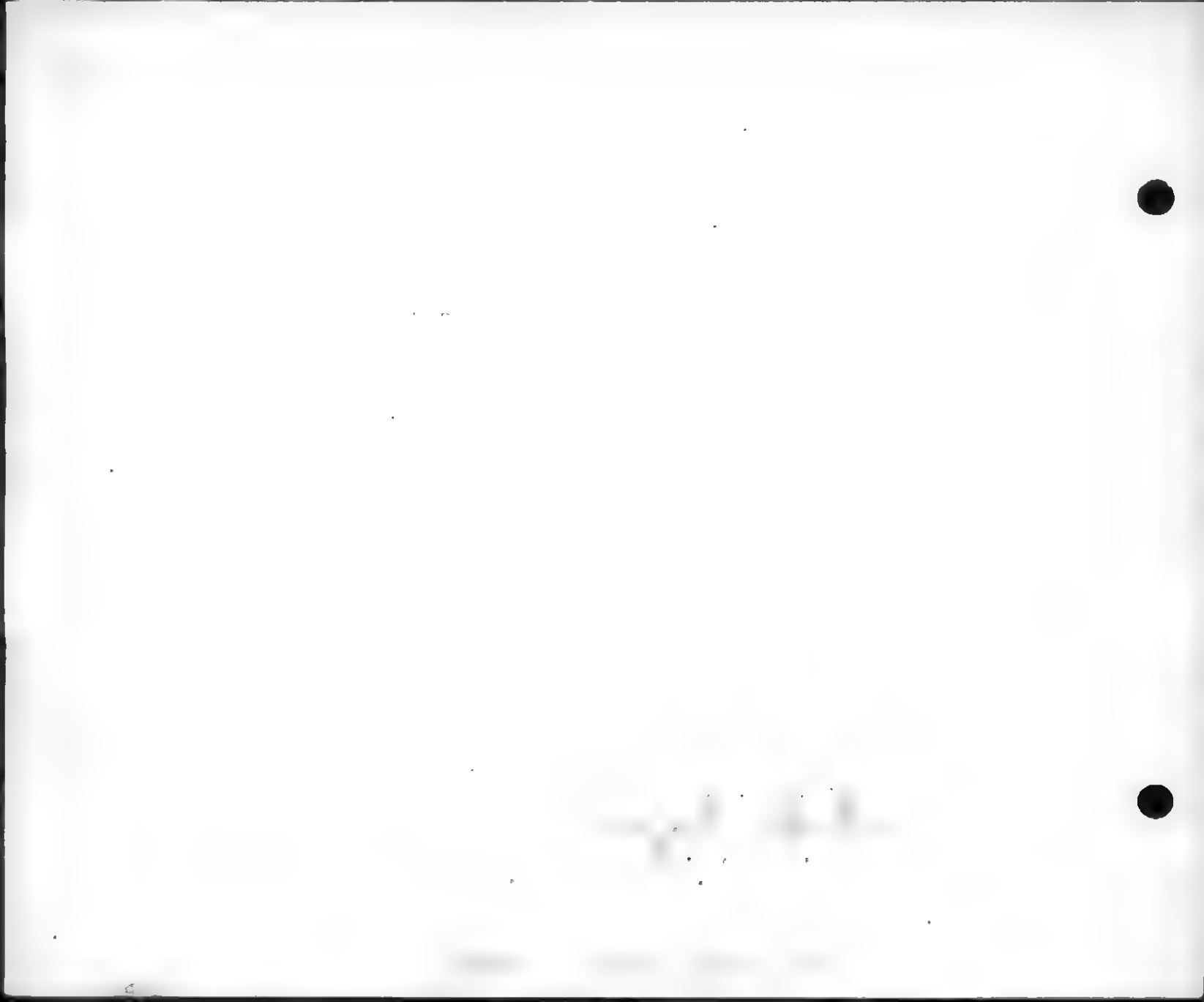
FOR STATE HEALTH DEPT

03017

04527

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, first institution Residence before admission) a STATE Maryland b COUNTY Wicomico	
b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Salisbury		c LENGTH OF STAY IN 1b Quantico	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d STREET ADDRESS R.F.D. 1	
e IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last Dominick Eugene Morris		4 DATE OF DEATH Month Day Year 2-28-66 19	
5 SEX M	6 CO. OR RACE AA	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 2-14-66
9 AGE (in years last birthday) yrs		F UNDER 1 YEAR Months 24 HOURS 19	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME R.C. Shivers		14. MOTHER'S MAIDEN NAME Edna Morris Quantico Md.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO.	
17. INFORMANT Edna Morris Quantico Md R.F.D. 1 box 48		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) Interstitial pneumonitis			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED 3-1-66	
EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Md.		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) burial	23b DATE THEREOF 2/4/1966	23c NAME OF CEMETERY OR CREMATORY Rockawalking	23d LOCATION (City or Town) (County) (State) Rockawalking Md.
24 FUNERAL DIRECTOR Clinton F. Stewart		25a REC'D BY REG. STRA MAR 9 1966	
25b REGISTRAR'S SIGNATURE John J. Jones			

1
M
FOR STATE HEALTH DEPT
This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

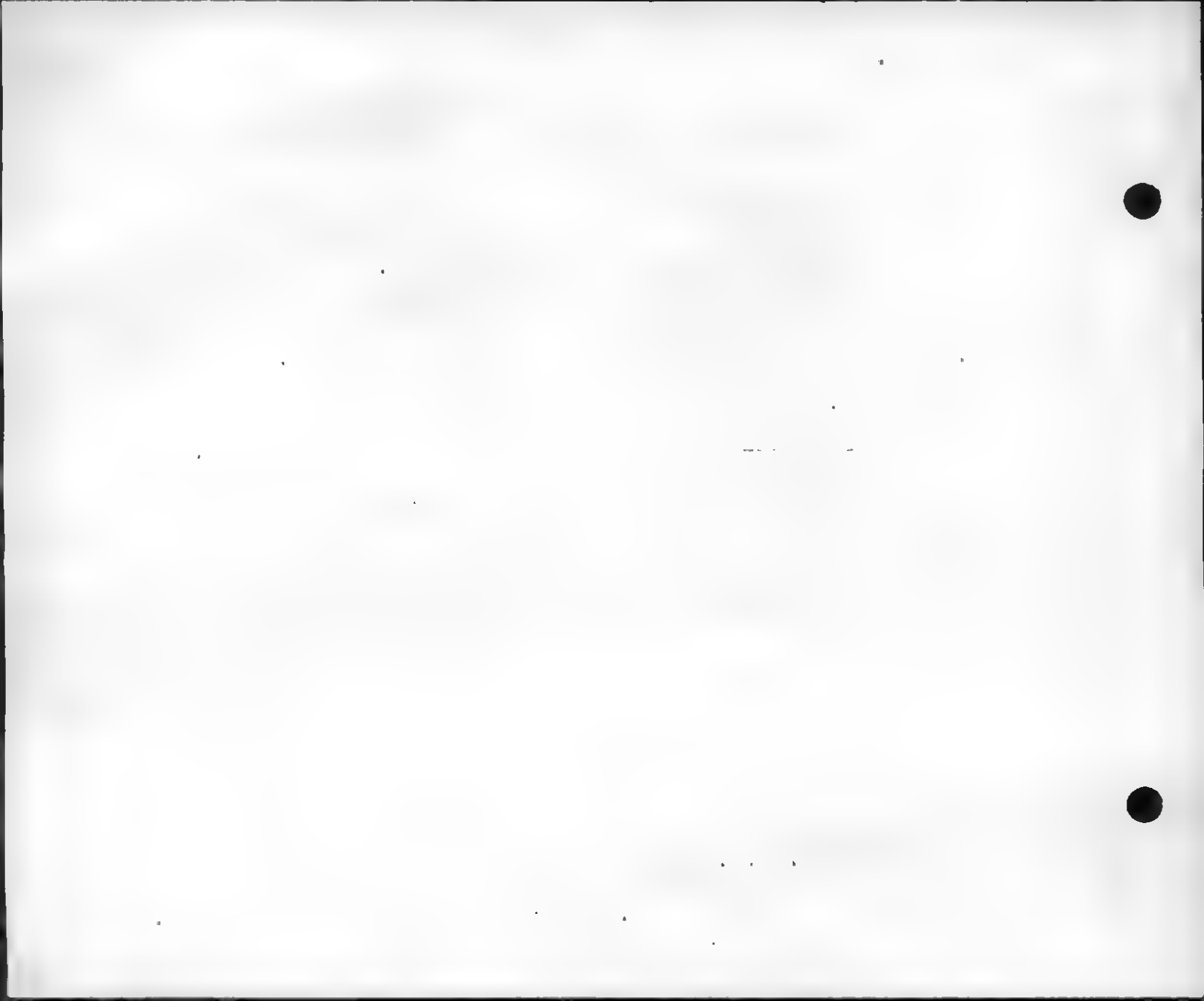
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

03018

CERTIFICATE OF DEATH

02004

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 30 yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 205 Elizabeth Street				d. STREET ADDRESS 205 Elizabeth			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last EDWIN NOCK SR.				4. DATE OF DEATH Month Feb Day 8 Year 19 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-6-1904	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rt. Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Trucks		11. BIRTHPLACE (County & State, or foreign country) Crisfield, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William C. Nock				14. MOTHER'S MAIDEN NAME Lena Parks			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-05-3763		17. INFORMANT Sue Nock, Delmar, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, bronchogenic DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 , to Feb 8, 1966 , that (I) (we) last saw the deceased alive on Feb 7, 1966 , and that death occurred at 11 M, from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-9-66	
22c. PHYSICIAN'S NAME (Type) Dr. L.V. Sohler				22d. ADDRESS Delmar, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-12-66		23c. NAME OF CEMETERY OR CREMATORY St. Stephens		23d. LOCATION (City, town or county) (State) Delmar, Del.	
24. FUNERAL DIRECTOR Charles W. Marmel				25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>5 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Pocomoke City</u> d. STREET ADDRESS <u>R.F.D. 3</u>	
3. NAME OF DECEASED (Type or print) <u>HAROLD FREEMAN PAYNE</u> 4. DATE OF DEATH <u>FEBRUARY 2 1966</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>OCT. 8, 1883</u> 9. AGE (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FORMER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u> 11. BIRTHPLACE (County & State, or foreign country) <u>WORCESTER COUNTY, MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN PAYNE</u> 14. MOTHER'S MAIDEN NAME <u>HESTER PAYNE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>-</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>RICHARD JONES, Pocomoke City, MD.</u> Address <u>R.F.D. 3</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonic</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>[REDACTED]</u> DUE TO (c) <u>[REDACTED]</u> INTERVAL BETWEEN ONSET AND DEATH <u>8-10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1) Thrombophlebitis of leg 2) Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-28, 1966</u> , to <u>2-2, 1966</u> that (I) (we) last saw the deceased alive on <u>2-2-1966</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James L. Clifford</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>2-2-66</u>		22c. PHYSICIAN'S NAME (Type) <u>JAMES L. CLIFFORD</u> 22d. ADDRESS <u>Medical Center Salisbury MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>2-6-1966</u> 23c. NAME OF CEMETERY OR CREMATORIUM <u>REMBON METHODIST</u> 23d. LOCATION (City, town or county) (State) <u>WORCESTER COUNTY, MARYLAND</u>		24. FUNERAL DIRECTOR <u>Robert H. Watson Pocomoke City, MD.</u> 25a. REC'D BY REGISTRAR <u>FEDS</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03020

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03006

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>4 WEEKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>East Potomac</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>				d. STREET ADDRESS <u>Box 46</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maxwell</u> Middle <u>Peabody</u> Last <u>Peabody</u>			4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>1966</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE-24-1885</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>S. ORANGE, N. J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HERBERT E. PEABODY</u>				14. MOTHER'S MAIDEN NAME <u>GEORGIE F. WIGHT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-46-5132</u>		17. INFORMANT <u>Mrs. Jeannette Peabody - Deal Island Md.</u>		Address <u>Deal Island Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arterial Thrombosis</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/15/66</u> , 19 <u>66</u> , to <u>2/12/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/11/66</u> , 19 <u>66</u> , and that death occurred at <u>6:12 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>2/12/66</u>		22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>FEB 15-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Deal Island Md.</u>	
24. FUNERAL DIRECTOR <u>L. S. Webster</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
25c. ADDRESS <u>Princess Anne</u>				DATE <u>FEB 17 1966</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

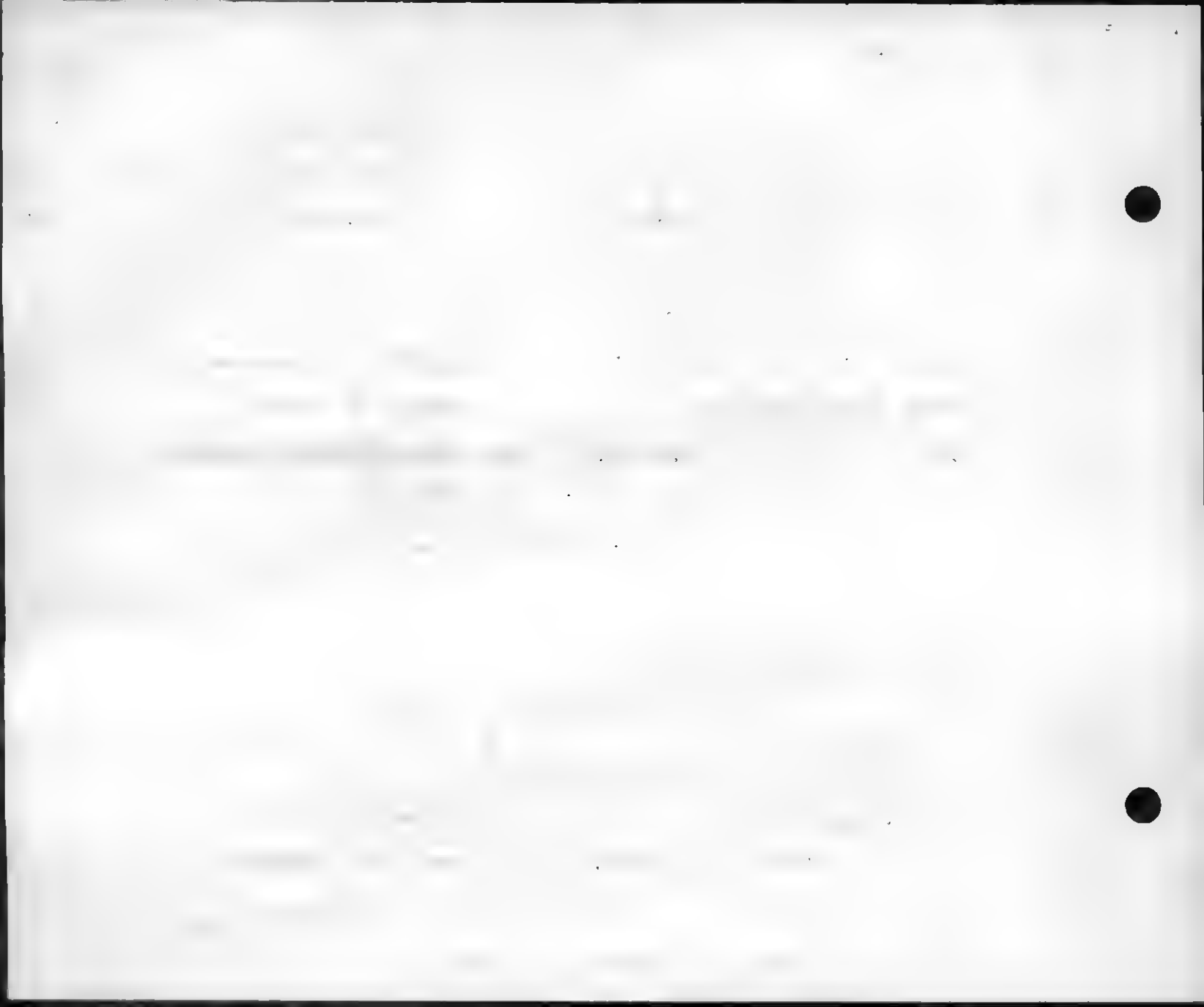
1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03021
CERTIFICATE OF DEATH

113007

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Pocomoke City</u> d. STREET ADDRESS <u>CEDAR HALL ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EMMA</u> First <u>ELIZABETH</u> Middle <u>Phillips</u> Last 4. DATE OF DEATH <u>FEBRUARY 22</u> 19 <u>66</u> Month Day Year				5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>FEB. 18, 1886</u> 9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> 11. BIRTHPLACE (County & State, or foreign country) <u>WORCESTER County MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>				13. FATHER'S NAME <u>HENRY CLAY OUTTEN</u> 14. MOTHER'S MAIDEN NAME <u>MARY RITCHIE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>-</u> 16. SOCIAL SECURITY NO. <u>216-05-0593</u> 17. INFORMANT <u>MRS LINWOOD McDANIEL</u> Address <u>Pocomoke City, MD</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction.</u> <u>4301</u> DUE TO <u>Atherosclerotic coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u> <u>Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/19/66</u> to <u>2/22/66</u> , that (I) (we) last saw the deceased alive on <u>2/22/1966</u> , and that death occurred at <u>9 P.M.</u> from the causes and on the date stated above.				22a. SIGNATURE <u>[Signature]</u> 22b. DATE SIGNED <u>2/22/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>OSWALD J. BURTON, M.D.</u> 22d. ADDRESS <u>SALISBURY, MARYLAND</u>				ATTENDING M.D. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>2-26-1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>FIRST BAPTIST</u> 23d. LOCATION (City, town or county) (State) <u>Pocomoke City, MARYLAND</u>				24. FUNERAL DIRECTOR <u>Robert H. Watson</u> ADDRESS <u>Pocomoke City, MD.</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>MAR 1 1966</u>			

MEDICAL CERTIFICATION



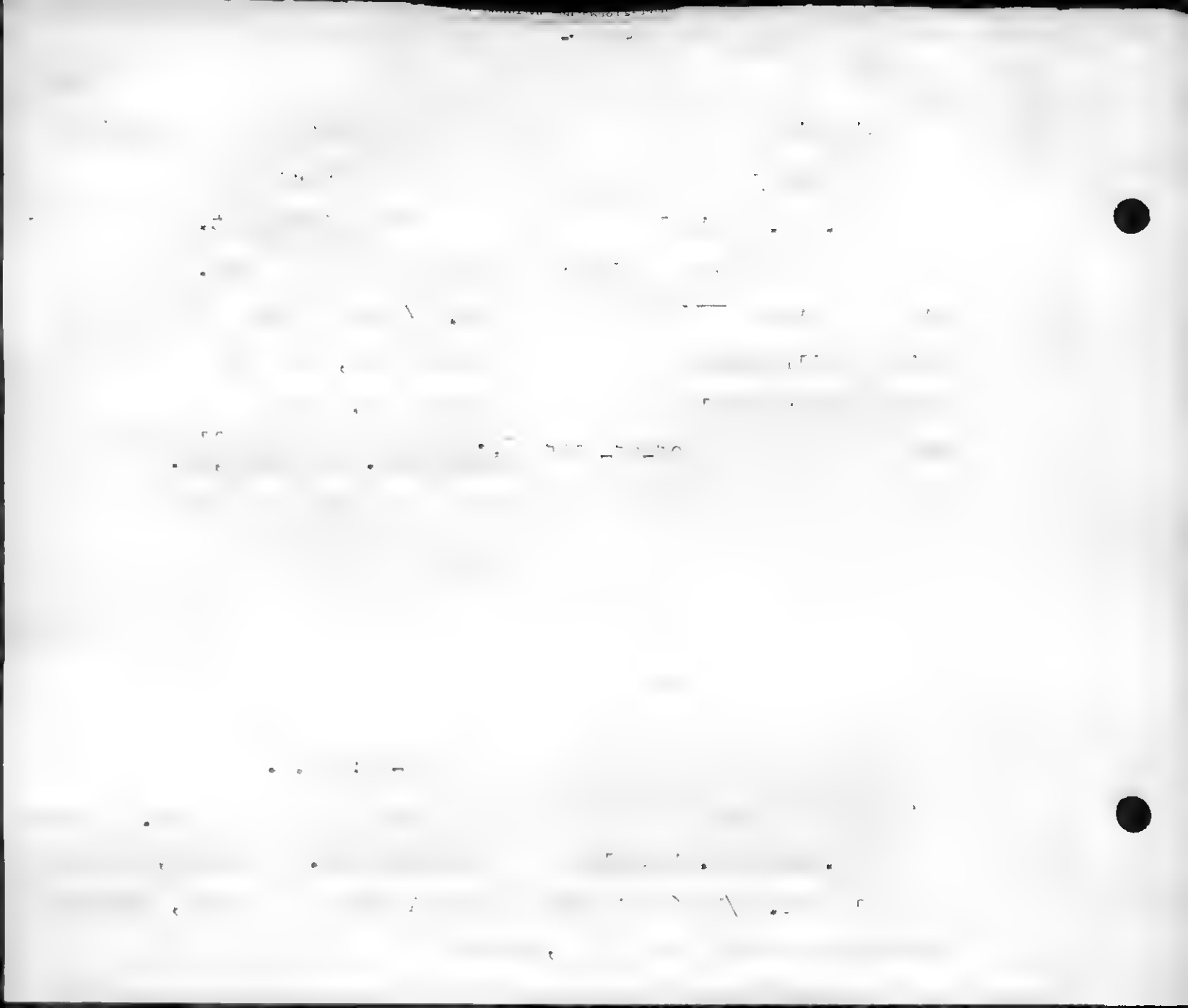
TO RESPOND OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pen.Gen.Hospital		d. STREET ADDRESS 622 Liberty St.	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle HENRY Last POWELL		4. DATE OF DEATH Month FEB. Day 24 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov.21/1901
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 3 Days 3 Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Railroadman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Henry Powell		14. MOTHER'S MAIDEN NAME Mattie B.Kelly	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 705-05-4735	
17. INFORMANT Mrs. Mildred Gordy Powell (Wife)		Address 622 Liberty St. Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, undifferentiated. 1992 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/29/65 to 19 , that (I) (we) last saw the deceased alive on 2/24/1966 , and that death occurred at App-12:10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Andrew C. Mitchell		22b. DATE SIGNED Feb. 26/1966	
22c. PHYSICIAN'S NAME (Type) Dr. Andrew C. Mitchell		22d. ADDRESS Maryland Ave. Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 27/1966	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	
25a. REC'D BY REGISTRAR DATE 10-10		25b. REGISTRAR'S SIGNATURE [Signature]	



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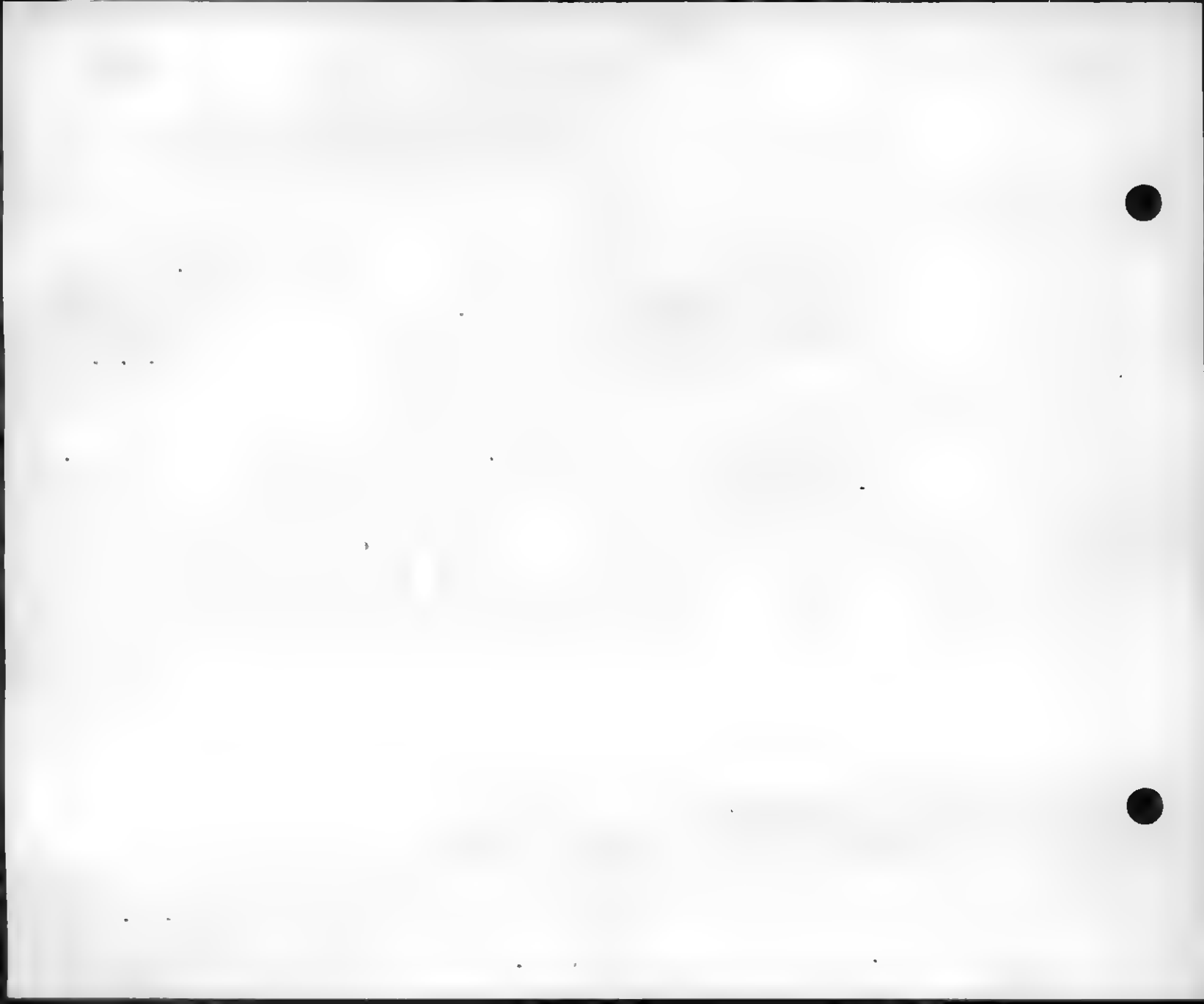
MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Item #79-film #537

02000

1. PLACE OF DEATH a. COUNTY WICOMICO		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN lb 5 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Princess Anne Sanatorium		d. STREET ADDRESS PRINCESS ANNE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) PEARL COLBORN POWELL		4. DATE OF DEATH Month FEB. Day 17 Year 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 11, 1885
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 8 Days 17 Hours 16 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ALLISON HOLLAND		14. MOTHER'S MAIDEN NAME ELIZABETH POWELL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT MRS. REGINALD CULLEN		Address CRISFIELD, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Myeloma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/8, 1958 , to 2/12, 1966 , that (I) (we) last saw the deceased alive on 2/12, 1966 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Charles J. Judge		22b. DATE SIGNED 2/19/66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2/19/1966	
23c. NAME OF CEMETERY OR CREMATORY MANOKIN PRESBYTERIAN		23d. LOCATION (City, town or county) (State) PRINCESS ANNE, MD.	
24. FUNERAL DIRECTOR LEVIN R. WILSON PRINCESS ANNE, MD.		25a. REC'D BY REGISTRAR MAR 1 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with this State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 M
FOR STATE
HEALTH DEPT.

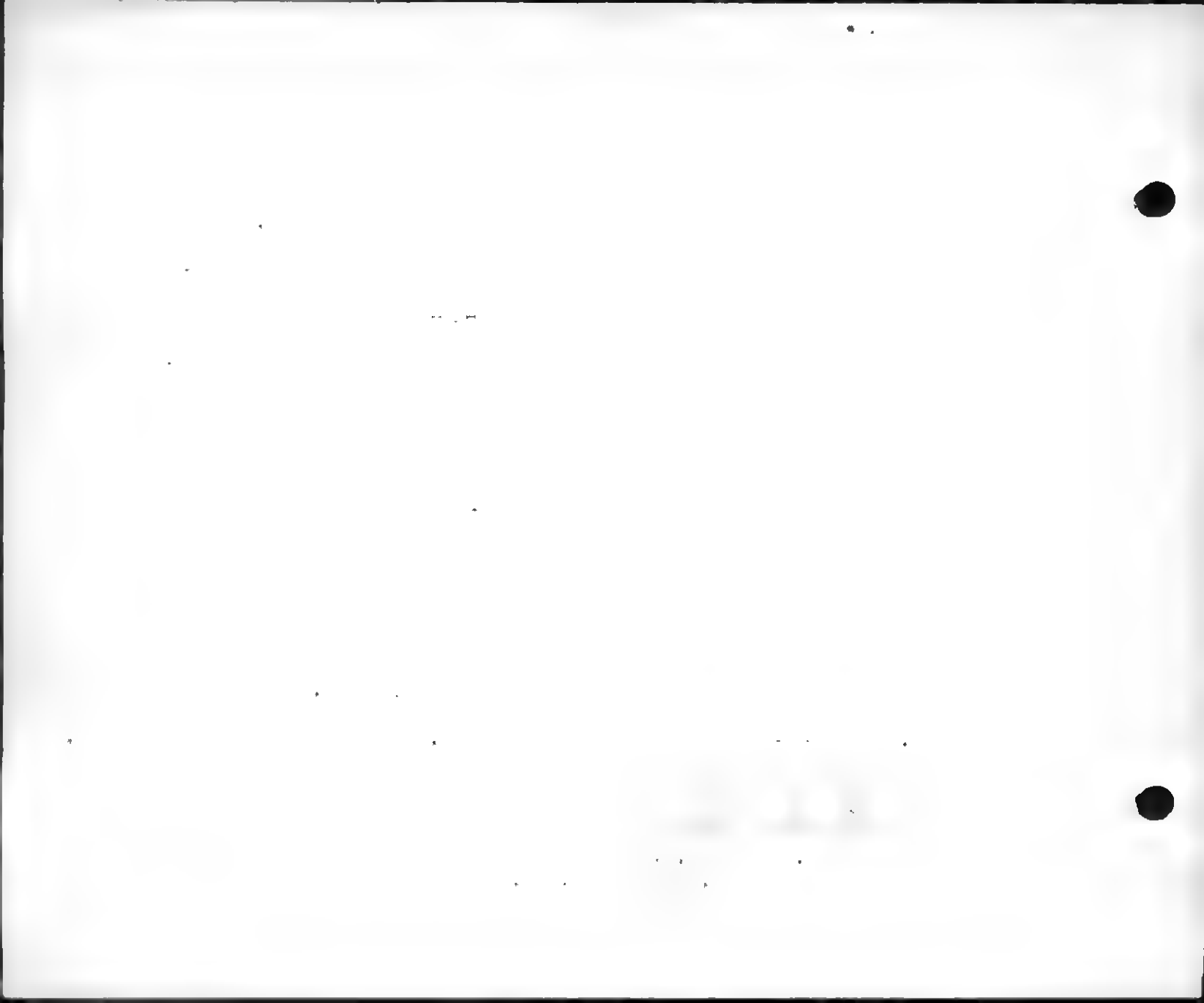
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

33024

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02010

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 414 Lake St.	
3. NAME OF DECEASED (Type or print) Kevin Wayne Pritchett		4. DATE 2-23-66 19 66	
5 SEX M		6. COLOR OR RACE C	
7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-10-61	
9 AGE (In years last birthday) 4 yrs		10 IF UNDER 1 YEAR Months Days	
11 BIRTHPLACE (State or foreign country) Salisbury		12. CITIZEN OF WHAT COUNTRY? us	
13 FATHER'S NAME Daniel Pritchett		14 MOTHER'S MAIDEN NAME Effie P.	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) none		16 SOCIAL SECURITY NO none	
17 INFORMANT Walter Pritchett Address Salisbury			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pseudomonas Septicemia DUE TO 7160 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Burns of 60 % of body surface DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 14 weeks	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Child burned during house fire.	
20c. TIME OF INJURY Month, Day, Year P.M. 12-27-65		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Own home.		20f. (City or town) Salisbury (County) Wicomico (State) Md.	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED 2-24-66	
ACTUAL SIGNATURE Earl L. Royer, M.D. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) 109 Camden Ave. Salisbury, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) Burial		23b. DATE THEREOF 2-27-66	
23c. NAME OF CEMETERY OR CREMATORY Union Cem		23d. LOCATION (City or Town) Frederick Md (County) Frederick (State) Md	
24 FUNERAL DIRECTOR Booker M. Wood ADDRESS Salisbury		25a. REC'D BY REGISTRAR MAR 3 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pen. Gen. Hospital		d. STREET ADDRESS R.D.#4 Cardinal Dr.	
3. NAME OF DECEASED (Type or print) First ANDREW Middle LEE Last PUSEY, SR.		4. DATE OF DEATH Month FEBRUARY Day 8 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5/1936
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - Tire Store		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 29 yrs. Months 9 Days 3 Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Marion Lee Pusey		14. MOTHER'S MAIDEN NAME Addie Parsons	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 219-34-3638	
17. INFORMANT Mrs. Rebecca H. Pusey (Wife)		Address R.D.#4 Cardinal Drive Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic C.A. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Embryonal C.A. testicular DUE TO (c)		21801 INTERVAL BETWEEN ONSET AND DEATH months yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 1955 to 2-8, 1966 , that (I) (we) last saw the deceased alive on 2-8, 1966 , and that death occurred at App. 11:30 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. Earl L. Royer		22b. DATE SIGNED Feb. 10 /1966	
22c. PHYSICIAN'S NAME (Type or print) Dr. Earl L. Royer		22d. ADDRESS 409 Camden Ave. Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Feb. 11/1966	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City, town or county) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR FEB 15 1966	
ADDRESS SALISBURY, MARYLAND		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GEORGETOWN</u> 46-3	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Consular General Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>Ellen</u> Last <u>Pusey</u>		4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-25-1898</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		9b. AGE (in years last birthday) <u>67</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CLAYTON ADKINS</u>		14. MOTHER'S MAIDEN NAME <u>IDA ADKINS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>222-16-7945</u>	
17. INFORMANT <u>PAUL PUSEY, Georgetown, Del.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>1551</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Carcinoma of the Gall Bladder</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 year?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9 Feb</u> , 19 <u>66</u> , to <u>10 Feb</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10 Feb</u> , 19 <u>66</u> , and that death occurred at <u>6:45</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Medical Center Salisbury, Maryland</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2-12-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MILLSBORO CEM.</u>	23d. LOCATION (City, town or county) (State) <u>MILLSBORO DEL.</u>
24. FUNERAL DIRECTOR <u>A. Borges Nelson, Frankford, Delaware</u> ADDRESS		25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



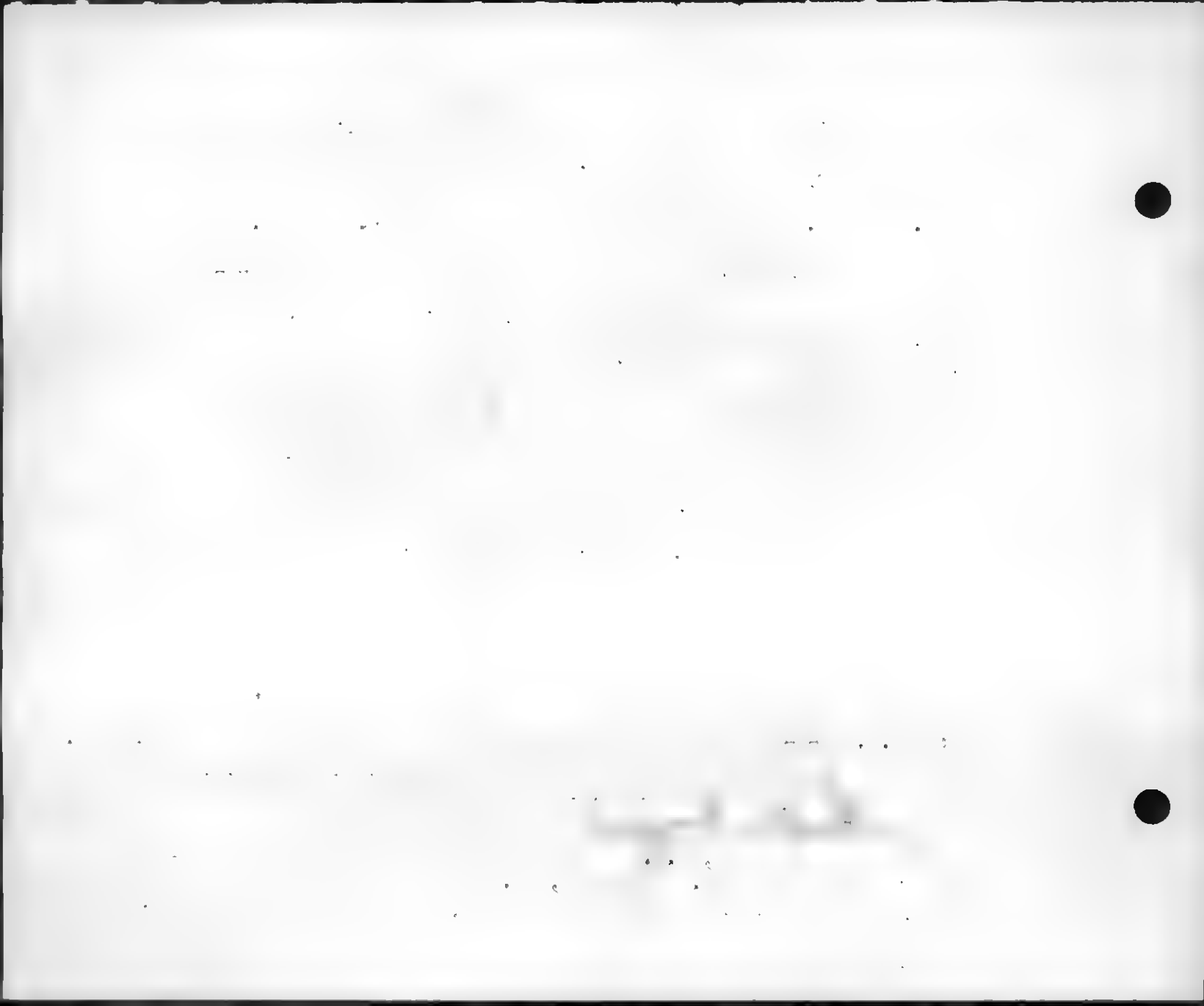
1
FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate is to be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
c. LENGTH OF STAY IN MD <u>5 yrs</u>		d. STREET ADDRESS <u>635 W. Main St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>635 W. Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u>		4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>66</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-10-44</u>	
9. AGE (In years last birthday) <u>21</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>11</u> Days <u>11</u> Hours <u>11</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Laurel Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Mary E Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Mary Reed</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>1100</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carbon monoxide poisoning</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Trapped in house during a house fire.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>8:30 A.M.</u> <u>2-9-66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <u>Home</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		22. DATE SIGNED <u>2-10-66</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Salisbury Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-13-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury Md</u>	
24. FUNERAL DIRECTOR <u>Booker M. West</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 15 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12014

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>md</u> <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>635 W. Main St.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>635 W. Main St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First Middle Last <u>Reed</u>		4. DATE OF DEATH Month Day Year <u>2-9-66</u> <u>19</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-18-1964</u> 2 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan Reed</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Mary Reed</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>1160</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carbon monoxide poisoning</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>11</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Trapped in house during a housefire.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>8:30</u> <u>April</u> <u>2-9-66</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u> EXAMINER'S NAME (Type) <u>400 Camden Ave. Salisbury, Md.</u>		22. DATE SIGNED <u>2-10-66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-13-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres Cem</u>		23d. LOCATION (city, town or county) (State) <u>Salisbury md.</u>	
24. FUNERAL DIRECTOR <u>Booker McNeal</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 15 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1954

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00015

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>635 W. Main St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>635 W. Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mark</u>		4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-64</u>
9. AGE (in years last birthday) <u>1</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan Reed</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs Mary Reed</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) <u>Carbon monoxide poisoning</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Trapped in house during a housefire.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>8:30</u> p.m. <u>2-9-66</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>409 Cambridge St. Salisbury</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-12-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Brown Peres</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury</u> <u>Md.</u>	
24. FUNERAL DIRECTOR <u>Dooper McNeil</u>		ADDRESS	
25a. REC'D BY REGISTRAR <u>FEB 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

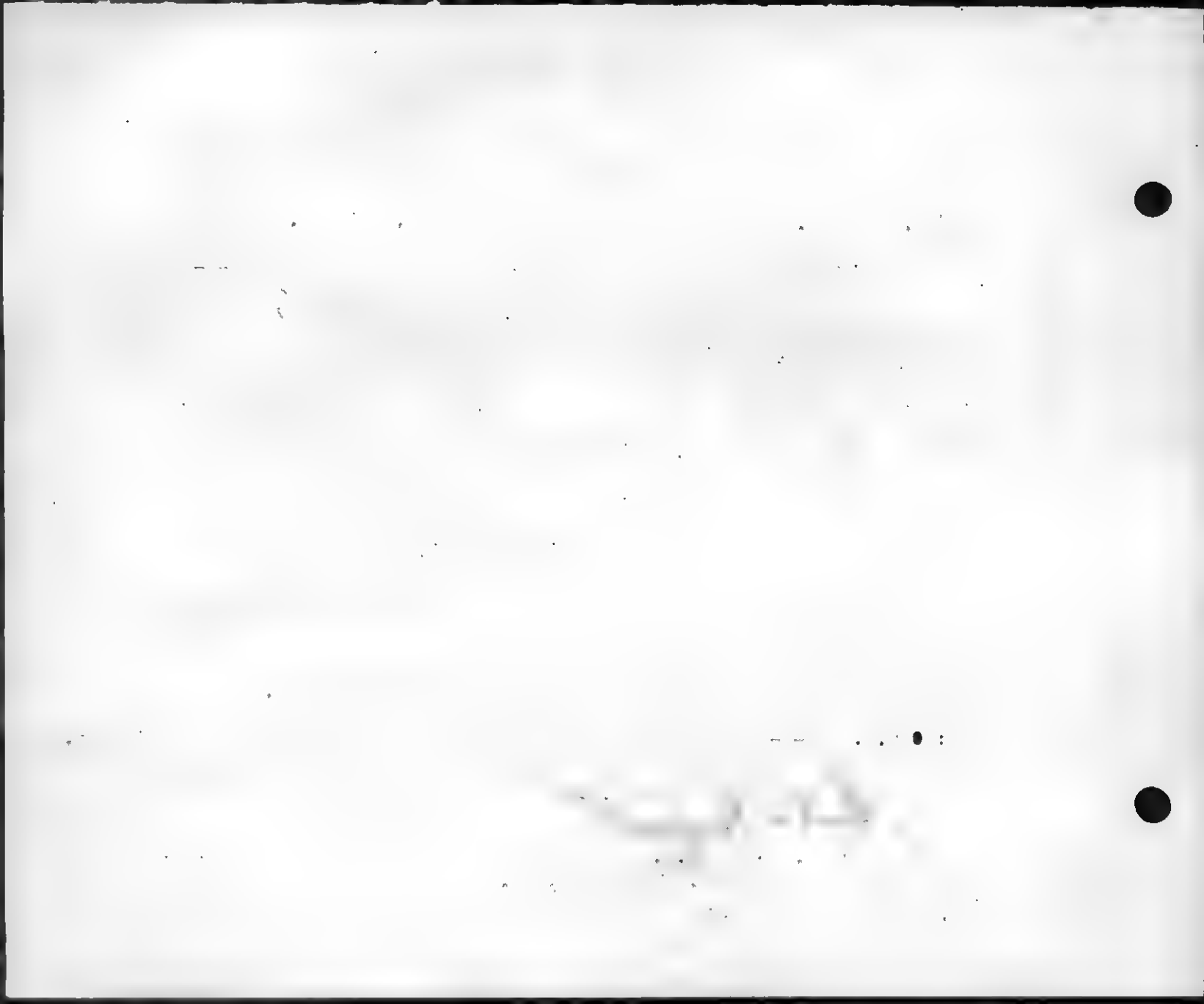
FOR STATE HEALTH DEPT

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>635 W. Main St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>635 W. Main St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nathan Reed</u>		4. DATE OF DEATH <u>2-9-66</u> 19 <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4-1924</u> 49 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>W-W. Horne</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wesley Reed</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Spamer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>217-12-4659</u>	
17. INFORMANT <u>Mary E. Reed</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carbon monoxide poisoning</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Trapped in home during a house fire.</u>	
20c. TIME OF INJURY Month, Day, Year <u>8:30 A.M. 2-9-66</u>	20d. INJURY OCCURRED <u>while at work</u> <input type="checkbox"/> <u>Not while at work</u> <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Id.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		22. DATE SIGNED <u>2-10-66</u>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-13-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>	23d. LOCATION (City, town or county) <u>Salisbury</u> (State) <u>Md.</u>
24. FUNERAL DIRECTOR <u>Brooks M. West</u>		25a. REC'D BY REGISTRAR <u>FEB 15 1966</u>	
ADDRESS _____		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02017

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>635 W. Main St.</u>				d. STREET ADDRESS <u>635 W. Main St.</u>			
3. NAME OF DECEASED (Type or print) <u>Little Nathan</u> First Middle Last				4. DATE OF DEATH <u>2-9-66</u> Month Day Year			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 23-65</u>	
9. AGE (In years last birthday) <u>8</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Salisbury Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Nathan Reed</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Johnson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>1160</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carbon monoxide poisoning</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Trapped in house during a housefire.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>8:30 PM</u> <u>2-9-66</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>				20f. (City or town) (County) (State) <u>Salisbury</u> <u>Wicomico</u> <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer, II, D.</u>				22. DATE SIGNED <u>2-10-66</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, II, D.</u>				Address (Street, city, town, or county) <u>1109 Garden Ave. Salisbury, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-13-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u>		23d. LOCATION (city, town or county) (State) <u>Salisbury Md</u>	
24. FUNERAL DIRECTOR <u>Frank McEwen</u>				25a. REC'D BY REGISTRAR <u>FEB 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

Cannot be matched with birth certificate.

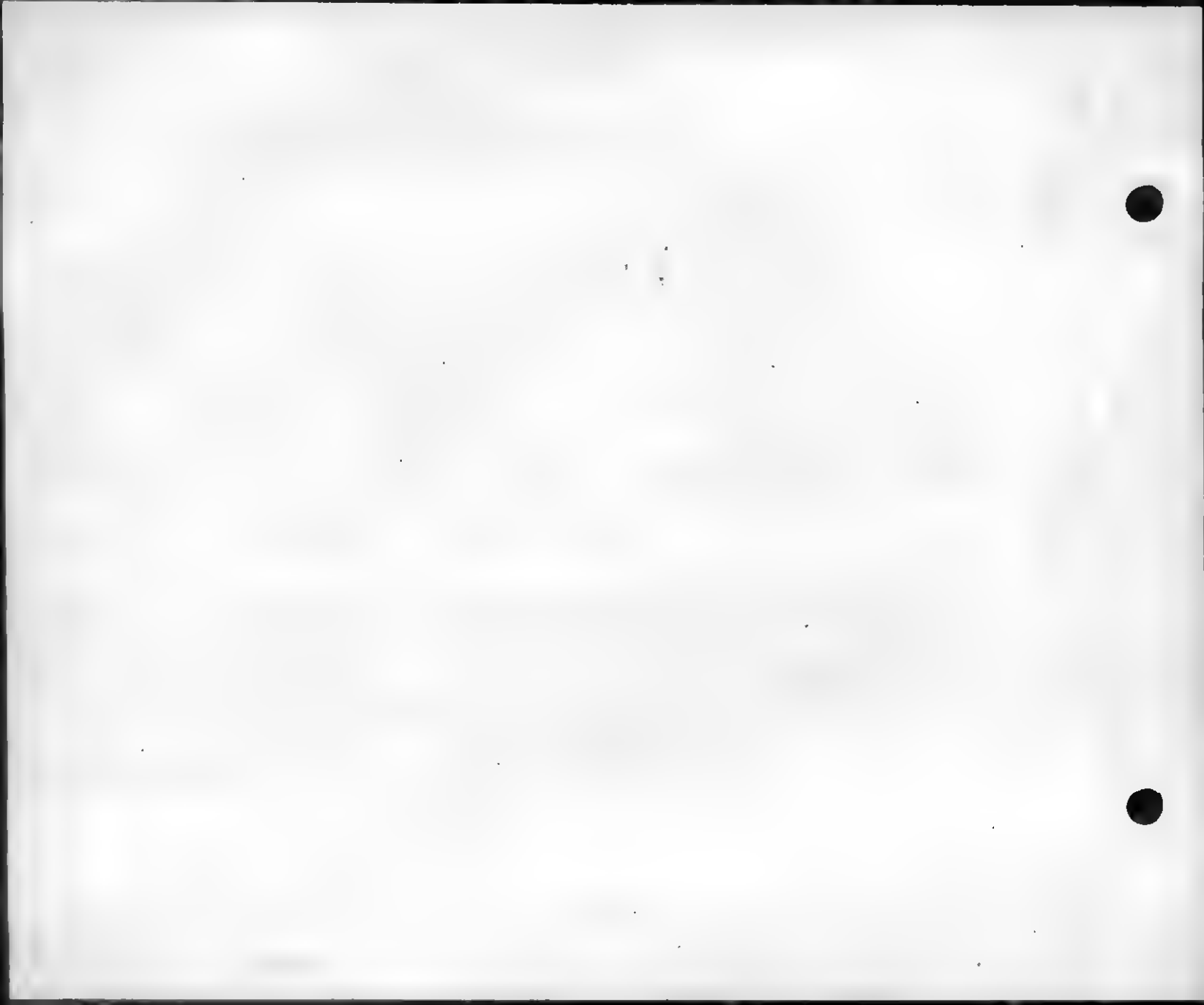
Entire family perished in fire. Contacted
Peninsula General Hospital, but birth
did not occur there. 3/16/66 - M.L.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02032
CERTIFICATE OF DEATH

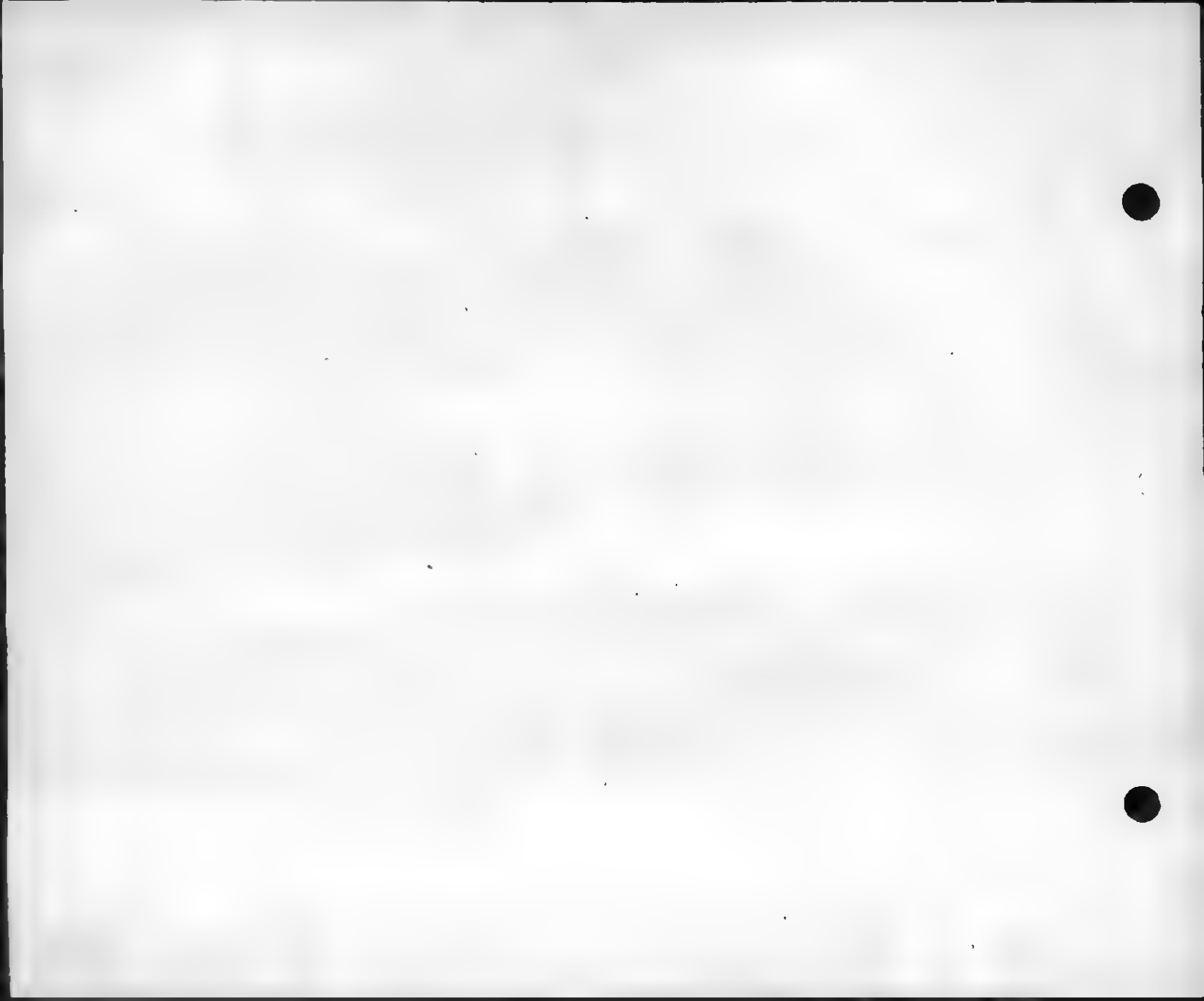
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b <i>MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Somerset</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Princess Anne</i>		d. STREET ADDRESS <i>Princess Anne</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>KENNETH Leon</i>		First <i>Leon</i>		Middle <i>Richard</i>		Last <i>RICHARDS</i>		4. DATE OF DEATH Month <i>FEBRUARY</i>		Day <i>10</i>		Year <i>1966</i>			
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec 13, 1928</i>		9. AGE (In years last birthday) <i>37</i> yrs.		IF UNDER 1 YEAR Months <i>3</i>		Days <i>7</i>		Hours <i>1</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Factory Worker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Gasoline Pumps</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Somerset Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>									
13. FATHER'S NAME <i>Russell Richards</i>		14. MOTHER'S MAIDEN NAME <i>Nancy Hurley</i>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Foreign Conflict</i>		16. SOCIAL SECURITY NO. <i>606-01-1000</i>		17. INFORMANT <i>Peggy Richards</i>		Address <i>Princess Anne</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Artery Thrombosis</i> (c) <i>with ventricular fibrillation</i>		19. INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <i>2/6</i> , 19 <i>66</i> , to <i>2/10</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>2/10</i> , 19 <i>66</i> , and that death occurred at <i>9:15</i> M, from the causes and on the date stated above.															
22a. SIGNATURE <i>James H. Sumner</i>		22b. DATE SIGNED <i>2/10/66</i>		22c. PHYSICIAN'S NAME (Type) <i>James H. Sumner</i>		22d. ADDRESS <i>Princess Anne, Md.</i>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/12/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Beechwood Memorial</i>		23d. LOCATION (City, town or county) (State) <i>Princess Anne Md</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. DATE <i>FEB 15 1966</i>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i> c. LENGTH OF STAY IN 1b <i>Salisbury</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Dorchester</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Federalsburg - Rural</i> d. STREET ADDRESS <i>Allen's Corner</i> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED First <i>Helen</i> Middle <i>Emma</i> Last <i>Koss</i>		4. DATE OF DEATH Month <i>February</i> Day <i>6</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 27, 1902</i>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	9. AGE (In years last birthday) <i>3</i> yrs. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) <i>Dorchester Co., Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Cannon</i>		14. MOTHER'S MAIDEN NAME <i>Olevia Cannon</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Atlas Ross, Federalsburg, Md., RFD</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i> DUE TO (b) <i>Pleurothoracic mass</i> DUE TO (c) <i>Stroke</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>2 days</i> <i>2 weeks</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>2/6/66</i> to <i>2/6/66</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>2/6/66</i> 19 <i>66</i> , and that death occurred at <i>3 P.</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <i>J. J. [Signature] and Son, Federalsburg, Maryland</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE		DATE <i>16 1966</i>	



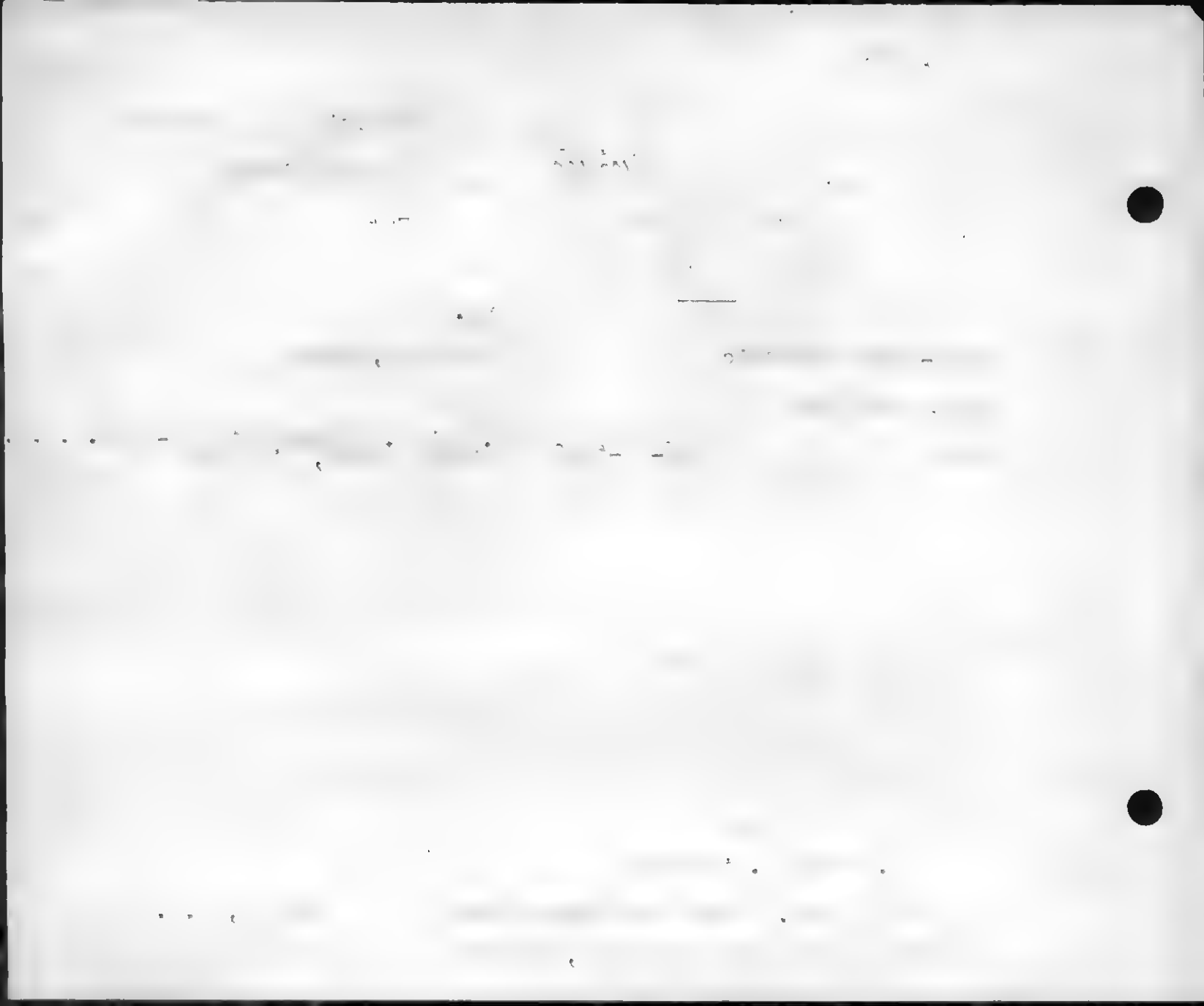
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VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
03034
CERTIFICATE OF DEATH
02020

1. PLACE OF DEATH a. COUNTY <u>Accomac</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>Adm. ID 1731766</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>JENNIFER GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomac</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wallops Island</u> d. STREET ADDRESS <u>K-11</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harold CHESTER Rowland</u>				4. DATE OF DEATH <u>FEBRUARY 7 1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 2/1914</u>	
9. AGE (in years last birthday) <u>51</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Arro-Space Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Mulberry, Kansas</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>				13. FATHER'S NAME <u>Lester Rowland</u>			
14. MOTHER'S MAIDEN NAME <u>(Unk)</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>036-24-6840</u>				17. INFORMANT <u>Mrs. Ruth E. Rowland (Wife)</u> Address <u>k-11 N.A.S.A. Wallops Island, Virginia</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> + a.o.l. DUE TO (b) <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (c) <u>Arteriosclerosis in many arteries</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>1 hour</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes, 0 years</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-31</u> , 19 <u>66</u> to <u>2-7</u> , 19 <u>66</u> , that (we) last saw the deceased alive on <u>2-7</u> , 19 <u>66</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph C. Fitzgerald</u>				22b. DATE SIGNED <u>2/7/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Joseph C. Fitzgerald</u>	
22d. ADDRESS <u>Medical Center Salisbury Md.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>Feb. 11/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hopkington Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Ashaway, R.I.</u>			
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY SALISBURY, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>553</u> OATE <u>10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	



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VR A15 (4)
15M 7-62

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Wicomico</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DELMAR</u>				c. LENGTH OF STAY IN TB <u>2 yrs.</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>415 East St.</u>				d. STREET ADDRESS <u>Same</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Addie Matilda Seward</u>				4. DATE OF DEATH <u>2 23 1966</u>				5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug 12, 1886</u> 9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Thomas Reed</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Quillen</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Walter Seward Delmar, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>CARDIAC FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>arteriosclerotic Heart Dis.</u> DUE TO (c) <u>unknown</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>100 Grove St. Delmar, Del.</u>			
20f. (City or town) (County) (State)				21. I certify that (I) (the hospital) attended the deceased from <u>6/10</u> , 19 <u>63</u> to <u>death</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/21</u> , 19 <u>66</u> and that death occurred at <u>3A</u> AM, from the causes and on the date stated above				22b. DATE SIGNED <u>2/23/66</u>			
22a. SIGNATURE <u>Ernest Larmore</u>				22c. PHYSICIAN'S NAME (Type) <u>Ernest M. Larmore</u>				22d. ADDRESS <u>100 Grove St. Delmar, Del.</u>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-26-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Templeville</u>			
23d. LOCATION (City, town or county) <u>Templeville, Maryland</u>				23e. (State) <u>Maryland</u>				25. REC'D BY REGISTRAR <u>FEB 28 1966</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulton Greenhouse, Md</u>				24b. ADDRESS <u>Templeville, Maryland</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

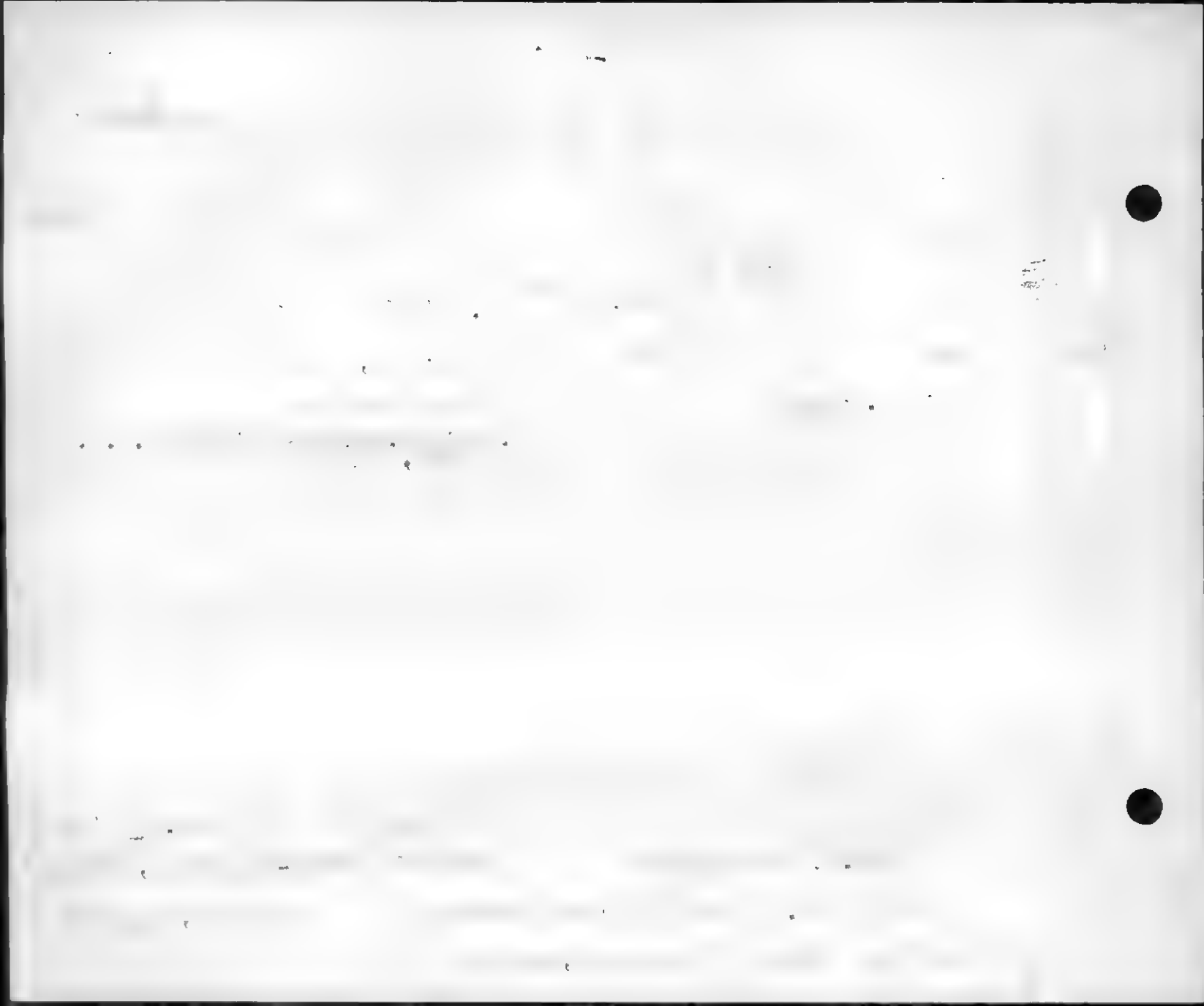
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

33036

110022

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Eden</u> d. STREET ADDRESS <u>Box 93</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY BOY		4. DATE OF DEATH Month <u>February</u> Day <u>12</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Baby DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 11/1966</u>	9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. yrs. <u>0</u> Months <u>0</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Maryland</u>	
13. FATHER'S NAME <u>David A. Seward</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. David A. Seward - (Father) - P.O.B. #93</u> <u>Eden, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity - 950 gms</u> 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>776x</u> DUE TO (c) <u>776x</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> , 19 <u>66</u> to <u>2/12</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/12</u> , 19 <u>66</u> , and that death occurred at <u>3:15</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>William C. Morgan</u>				22b. DATE SIGNED <u>Feb. 14/1966</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>Dr. William Morgan</u>				22d. ADDRESS <u>Medical Center-Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Feb. 14/1966</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY, MARYLAND</u>		25a. REC'D BY REGISTRAR <u>FEB 15 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03037

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18023

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c LENGTH OF STAY IN 1b Snow Hill	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d STREET ADDRESS Snow Hill	
3 NAME OF DECEASED (Type or print) Avery D Shockley		4 DATE OF DEATH Month 2 Day 19 Year 66	
5 SEX M	6 COLOR OR RACE W	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Nov. 18, 1906
9 AGE (in years last birthday) 59		IF UNDER 1 YEAR Months 5 Days 5 Hours 58	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storekeeper		10b KIND OF BUSINESS OR INDUSTRY Seafood	
11 BIRTHPLACE (State or foreign country) Snow Hill, Maryland		12 CITIZEN OF WHAT COUNTRY? USA	
3 FATHER'S NAME George C. Shockley		14 MOTHER'S MAIDEN NAME Laura G. Hearne	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		6 SOCIAL SECURITY NO 214164820	
17 INFORMANT Josephine Davis, Salisbury, Md.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sudden DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Passenger in car involved in collision with another car	
20c TIME OF INJURY Month, Day, Year 6:45 P.M. 2-19-66		20d INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input checked="" type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Rt 113 at Rt. 50		20f (City or town) (County) (State) Berlin Worcester Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED 2-21-66	
EXAMINER'S NAME (Type) 109 Camden Ave. Salisbury, Md.		DEPUTY MED. EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 2/22/66	23c NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery	23d LOCATION (City or town) (County) (State) Snow Hill, Maryland
24. FUNERAL DIRECTOR Norman F. Williams		25a REC'D BY REGISTRAR FEB 24 1966	
ADDRESS Snow Hill, Maryland		25b REGISTRAR'S SIGNATURE Charles Judge	

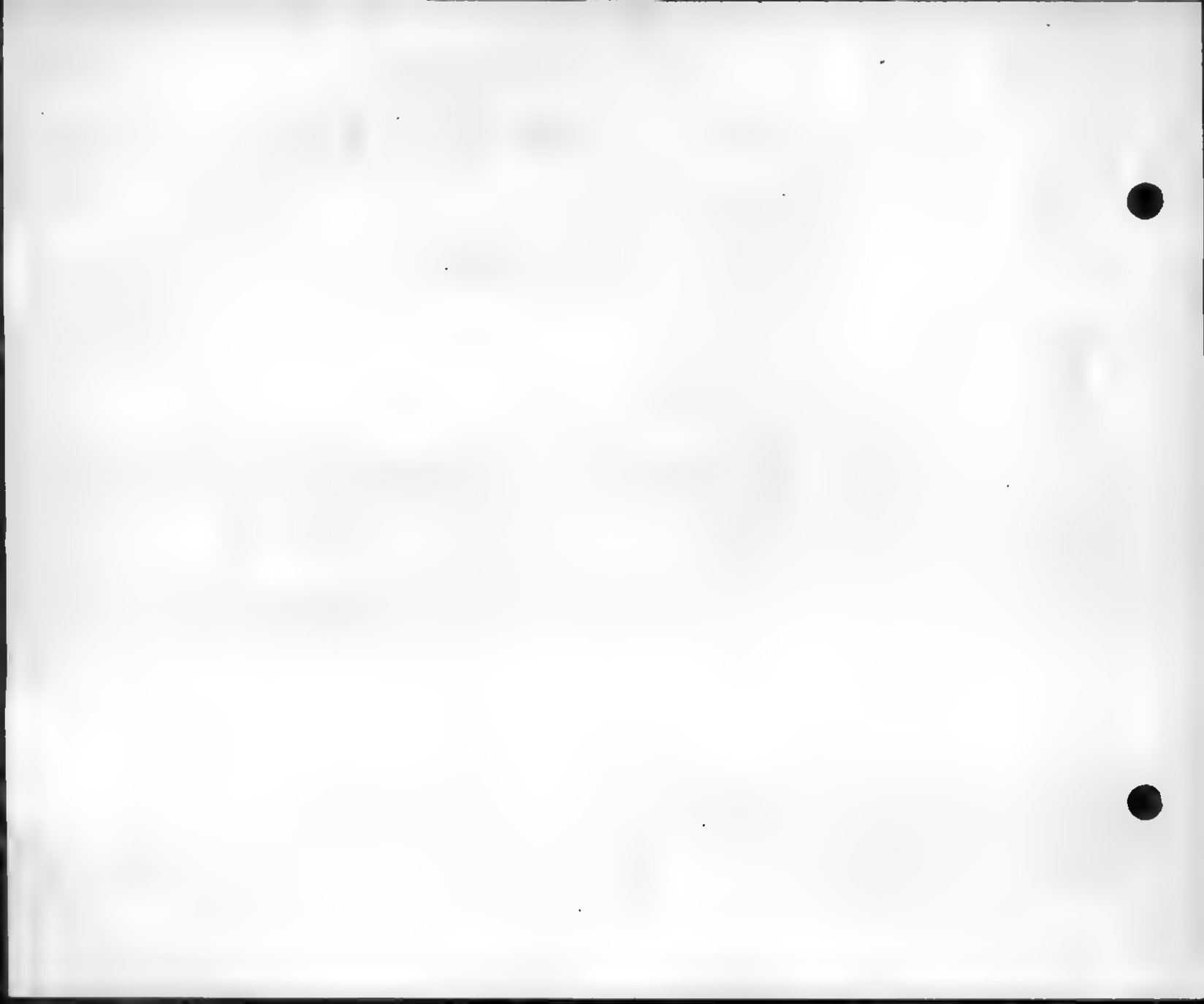
2-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u> d. STREET ADDRESS <u>R.F. 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM G SINNAMON</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>FEBRUARY 25 1966</u> Month Day Year 8. DATE OF BIRTH <u>JAN 23, 1903</u> 9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRIAL MAGISTRATE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>COUNTY</u> 11. BIRTHPLACE (County & State, or foreign country) <u>PHILADELPHIA PA.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>WILLIAM SINNAMON</u> 14. MOTHER'S MAIDEN NAME <u>VIRGINIA SMITH</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>2-1-28-3341</u> 17. INFORMANT <u>MRS. W. G. SINNAMON</u> Address <u>OCEAN CITY MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Artery Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____		21. I certify that (I) (this hospital) attended the deceased from <u>2/21</u> , 19 <u>65</u> , to <u>2/24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/24</u> , 19 <u>66</u> , and that death occurred at <u>1A</u> M, from the causes and on the date stated above. 22a. SIGNATURE <u>Charles J. Judge</u> 22b. DATE SIGNED _____ 22c. PHYSICIAN'S NAME (Type) _____ 22d. ADDRESS _____ 22e. M.D. ATTENDING PHYS. <input type="checkbox"/> 22f. MED. DIRECTOR <input type="checkbox"/> 22g. STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>2/27/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>SWANSETT MEMORIAL</u> 23d. LOCATION (City, town or county) (State) <u>BEALIX MD.</u>		24. FUNERAL DIRECTOR <u>Anna A. Burbage</u> Address <u>Berlin Md.</u> 25a. REC'D BY REGISTRAR <u>MAR 3 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

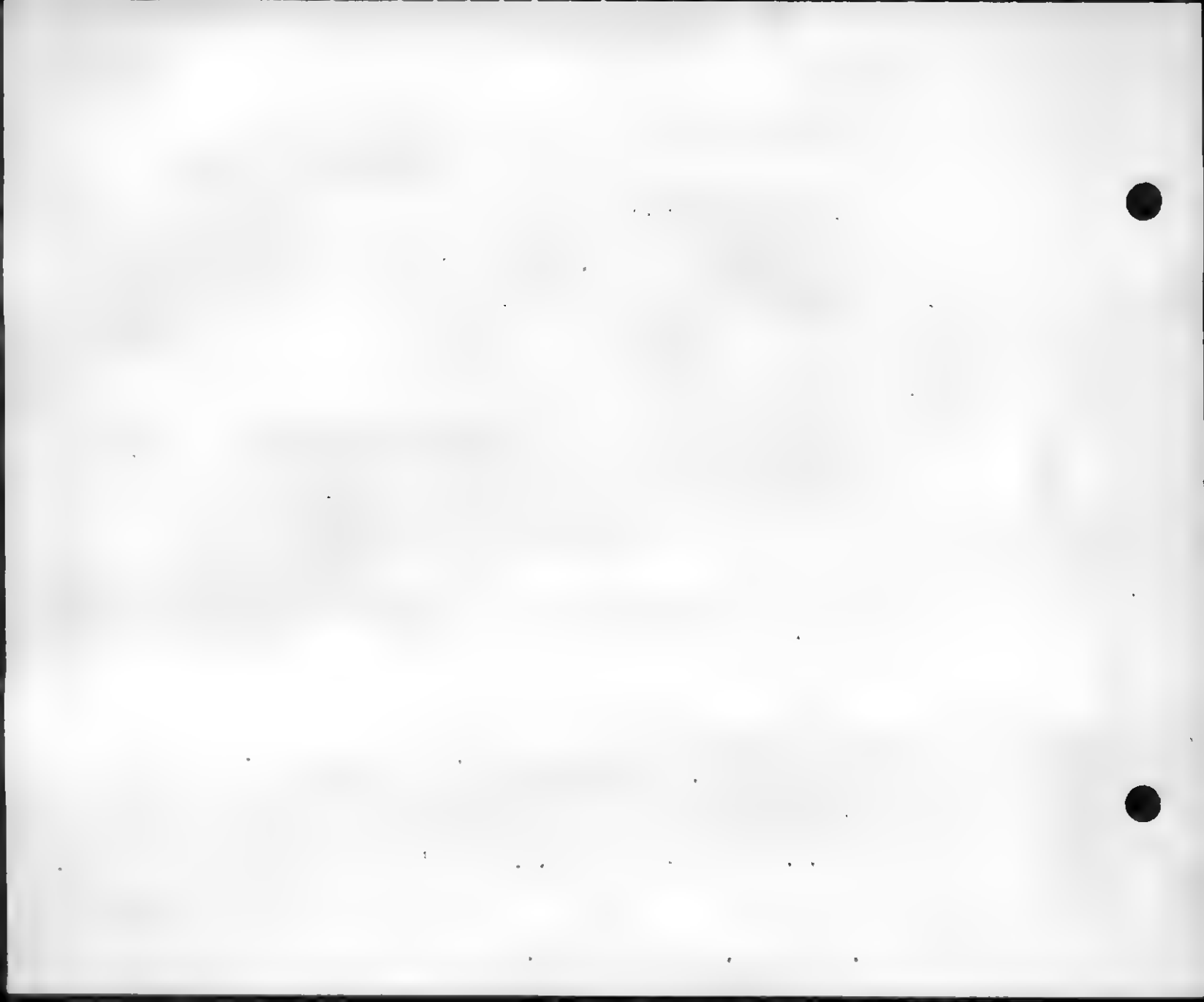


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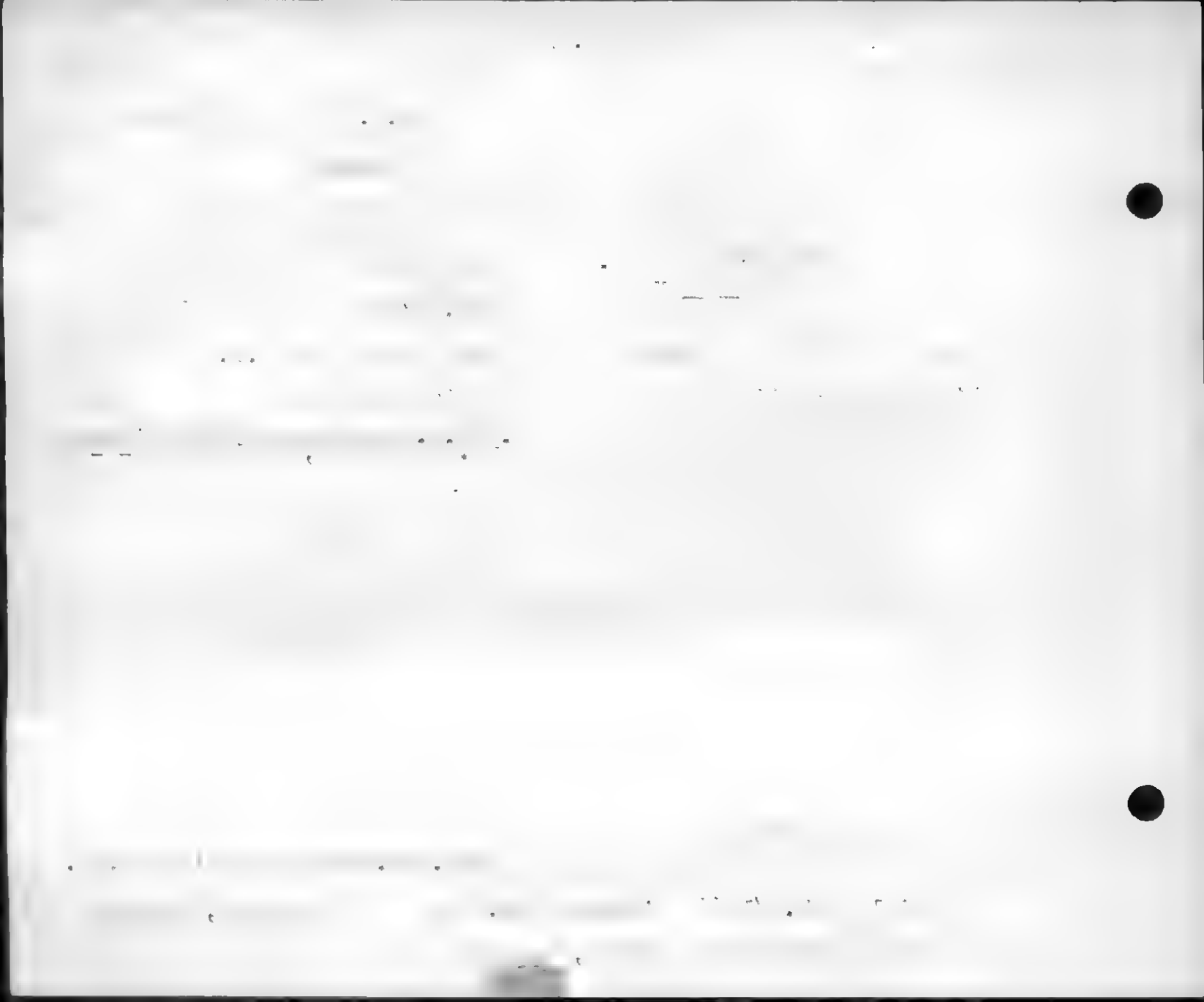
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02025
02025
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne, Maryland	
c. LENGTH OF STAY IN lb 7 days		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle B. Last Smith		4. DATE OF DEATH Month February Day 6 Year 19 66	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/11/98
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Bessie Smith		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Lovie Dashfield Princess Anne, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right descending coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease with mitral insufficiency DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Minutes Yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CA of prostate		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 27 , 19 66 , to Feb. 6 , 19 66 , that (I) (we) last saw the deceased alive on Feb. 6 , 19 66 , and that death occurred at 11A M. from the causes and on the date stated above.			
22a. SIGNATURE C.F. Gutierrez-Garrido, M.D.		22b. DATE SIGNED 2/7/66	
22c. PHYSICIAN'S NAME (Type) C.F. Gutierrez-Garrido, M.D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/11/66	
23c. NAME OF CEMETERY OR CREMATORY St Paul		23d. LOCATION (City, town or county) (State) Mt Vernon, Maryland	
24. FUNERAL DIRECTOR William H. James Jr. Princess Anne, Md		25a. REC'D BY REGISTRAR FEB 10 1966	
		25b. REGISTRAR'S SIGNATURE Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
22040 22026										
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>N.J.</u> b. COUNTY <u>Gloucester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wenonah</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>MARGUERITE C.</u> First Middle Last					4. DATE OF DEATH <u>February 1</u> 19 <u>66</u> Month Day Year					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 22/1893</u>		9. AGE (In years last birthday) <u>72</u> yrs. <u>1</u> Months <u>9</u> Days <u>9</u> Hours <u>9</u> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York City N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William McDonald</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Brady</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Edw. B. Swan (Husband)</u> Address <u>325 Princeton Ave., Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>renal failure</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>central vascular accidents (thrombosis)</u> INTERVAL BETWEEN ONSET AND DEATH <u>instant</u> <u>one week</u>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1/25/66</u> , 19 <u>66</u> to <u>2/1/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/1/66</u> , 19 <u>66</u> , and that death occurred at <u>4:50</u> M, from the causes and on the date stated above.										
22a. SIGNATURE <u>Robert H. Hising</u> M.O.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/1/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Pen. Gen. Hospital Salisbury, Md.</u>					22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 4/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Mem. Park</u>			23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>			
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u>					25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

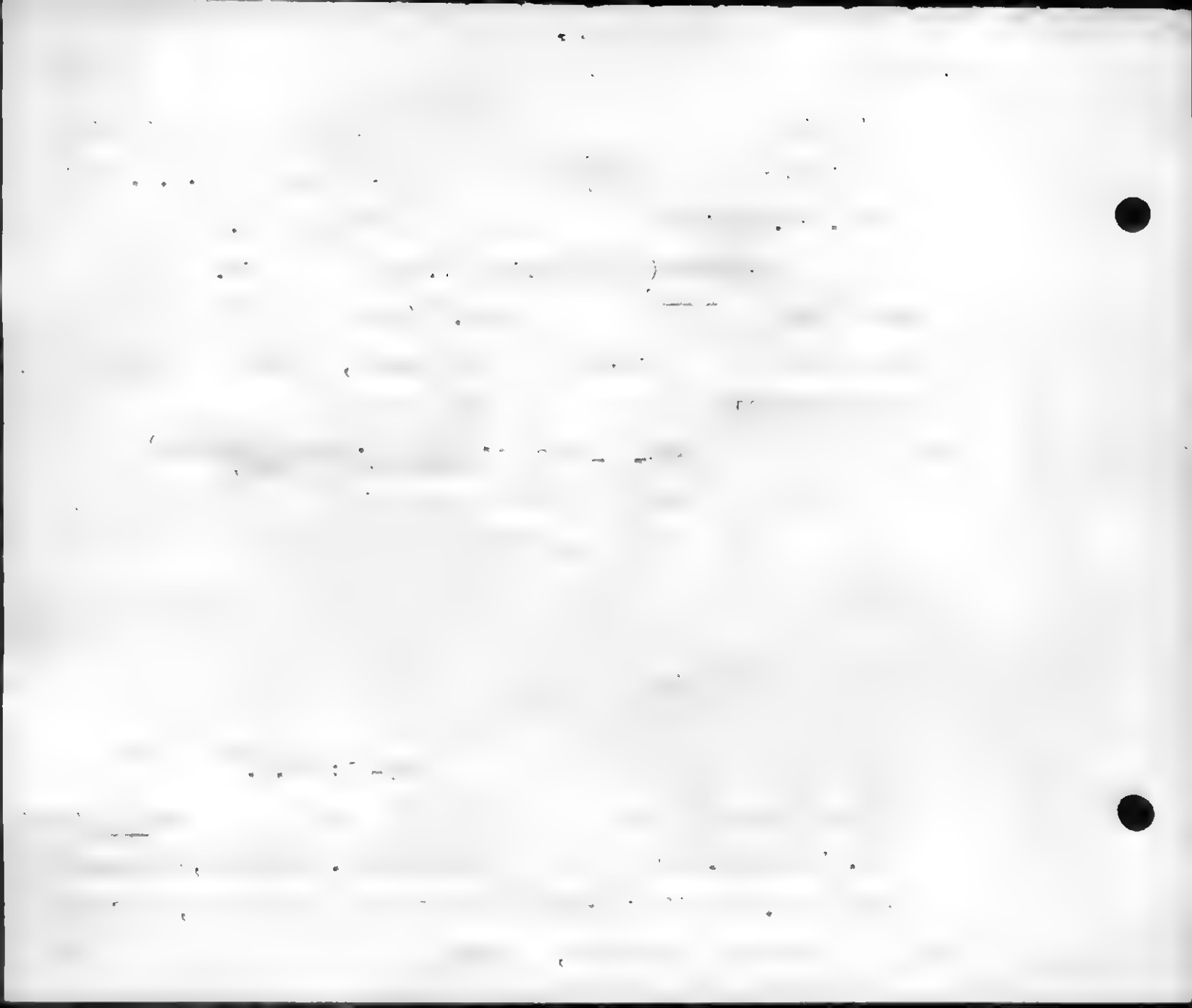
02041

101128

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fruitland (P.O.B.#443)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pen.Gen.Hospital				d. STREET ADDRESS Hayward Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last KATHERINE(KATIE) ANNA TOMLIN				4. DATE OF DEATH Month Day Year FEB. 14 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov.13/1888	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY None		9. AGE (in years last birthday) 77 yrs.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Charlie Cathell				12. CITIZEN OF WHAT COUNTRY? U S A			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (if yes give war or dates of service) No				14. MOTHER'S MAIDEN NAME Lena Bachman		16. SOCIAL SECURITY NO. 219-12-5273	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decomensation DUE TO (b) Degenerative Heart Disease DUE TO (c) apnea Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 2.5 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 11 1966 to Apr 11 1966 , that (I) (we) last saw the deceased alive on Apr 11 1966 , and that death occurred at 11:50 P.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>William D. Gray</i>				22b. DATE SIGNED Feb 17 1966		22c. PHYSICIAN'S NAME (Type) Dr. William D. Gray	
22d. ADDRESS Camden Ave, Salisbury, Maryland				22e. REC'D BY REGISTRAR FEB 21 1966		22f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb.17/1966		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY				25. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.


TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

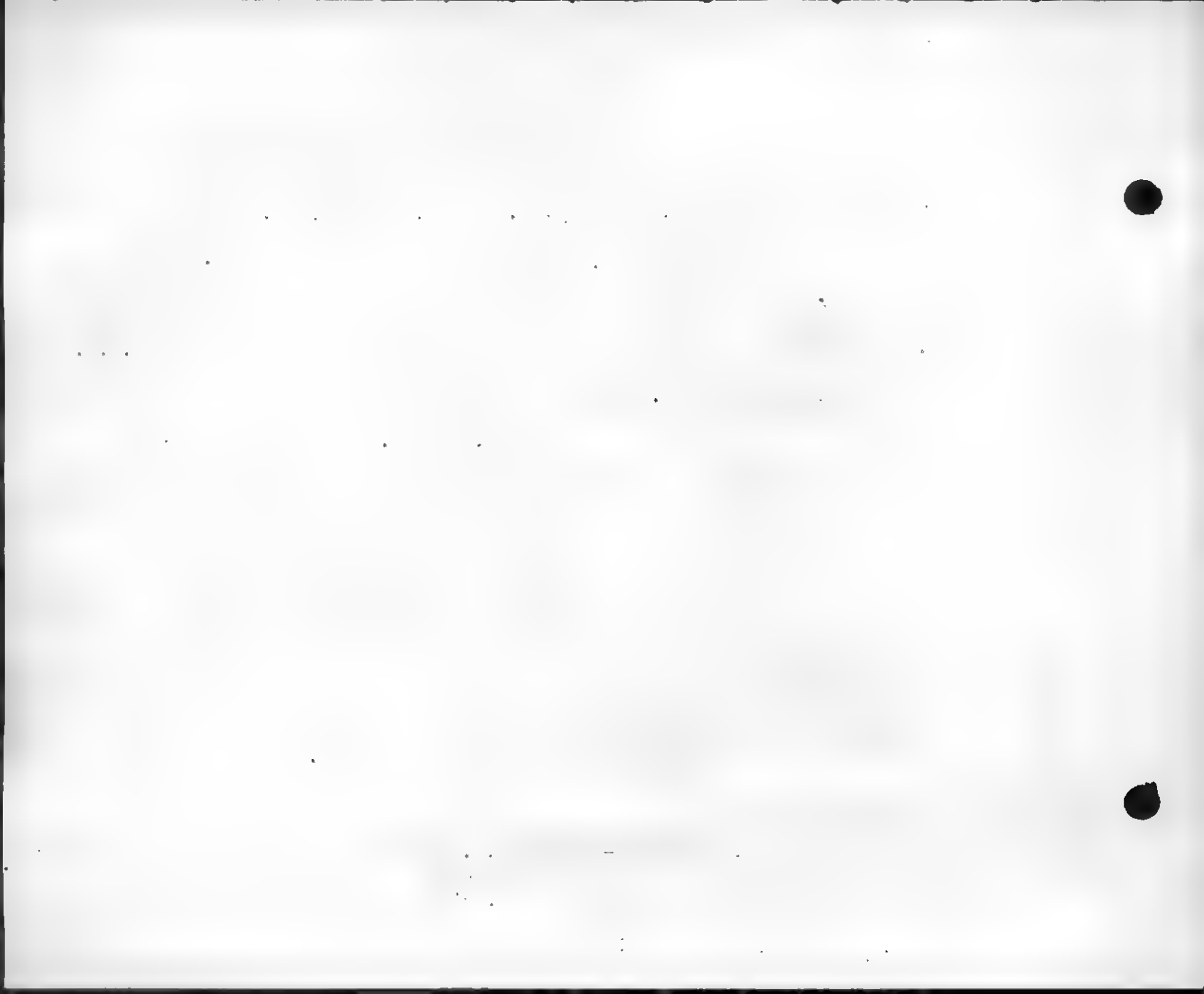


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

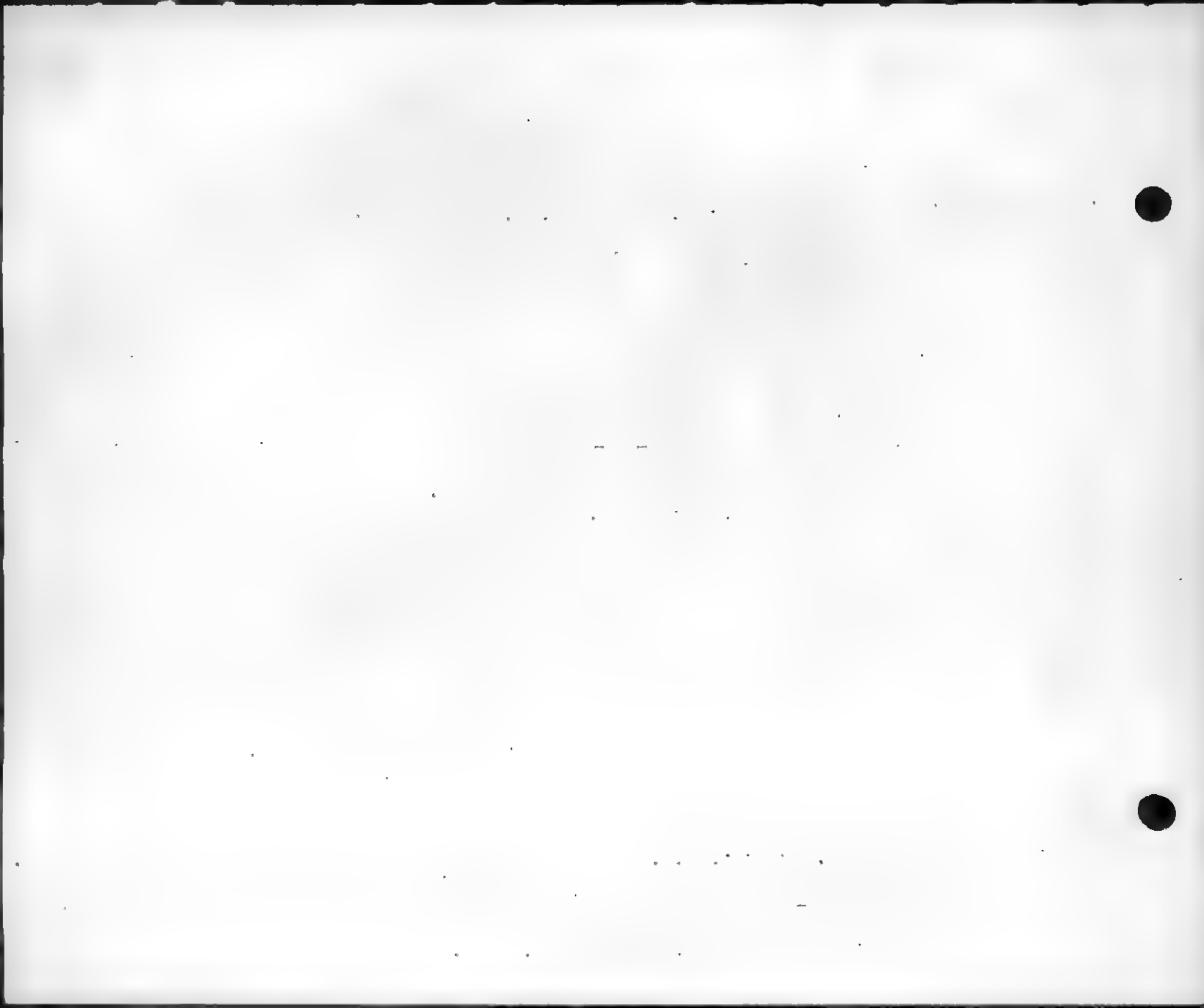
<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.						d. STREET ADDRESS 642 S. Division St.					
3. NAME OF DECEASED (Type or print) First Ernest Middle W. Last Townsend						4. DATE OF DEATH Month Feb. Day 23 Year 1966					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 21, 1900		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. NURSERYMAN						10b. KIND OF BUSINESS OR INDUSTRY OWNER		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ERNEST W? TOWNSEND, SR.						14. MOTHER'S MAIDEN NAME AMELIA SHOCKLEY					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)						16. SOCIAL SECURITY NO. 		17. INFORMANT Address MRS. HUGH W. DAUM, CRETE, ILLINOIS			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CA of the stomach with advanced metastasis 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 										INTERVAL BETWEEN ONSET AND DEATH Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 2/1 , 19 66 , to 2/23 , 19 66 , that (I) (we) last saw the deceased alive on 2/23 19 66 , and that death occurred at 9:00 A.M. from the causes and on the date stated above.											
22a. SIGNATURE 						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 2/23/66			
22c. PHYSICIAN'S NAME (Type) C. F. Gutierrez-Garrido, M.D., Deer's Head State Hospital, Salisbury						22d. ADDRESS 					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 2/26/1966		23c. NAME OF CEMETERY OR CREMATORY WICOMICO MEM. PARK		23d. LOCATION (City, town or county) (State) SALISBURY, MARYLAND				
24. FUNERAL DIRECTOR George C. Hill						25a. REC'D BY REGISTRAR Salisbury, Md.		25b. REGISTRAR'S SIGNATURE FEB 23 1966			



TO HOSPITAL OR INTERVIEWING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. LENGTH OF STAY IN 1b <u>1 day</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital, Salisbury, Md.</u>						d. STREET ADDRESS <u>Route #3, Pocomoke City</u>					
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Samuel</u> Last <u>Trent</u>						4. DATE OF DEATH Month <u>February</u> Day <u>9</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 21, 1902</u>		9. AGE (in years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS. Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Florida</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>unknown</u>						14. MOTHER'S MAIDEN NAME <u>unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>253-18-0589</u>		17. INFORMANT <u>Thomas Ward, Pocomoke City, Maryland</u>				Address <u>R.F.D. 3</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of esophagus with metastasis to mediastinum and abdomen.</u> 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>February 8, 1966</u> , to <u>Feb. 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>February 9, 1966</u> , and that death occurred at <u>8:25 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>V. Guerman</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2/9/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>V. Guerman, M.D.</u>						22d. ADDRESS <u>Deer's Head State Hospital, Salisbury, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-17-1966</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Mt. Olivet Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Somerset County, Maryland</u>		
24. FUNERAL DIRECTOR <u>Robert H. Watson</u>						ADDRESS <u>Pocomoke City, Md.</u>		25a. REC'D BY REGISTRAR <u>17 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12031**

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 7 Mons.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Gardens Apartments				d. STREET ADDRESS Glenn Gardens Apartments			
3. NAME OF DECEASED (Type or print) First Middle Last RAYMOND KING TRUITT				4. DATE OF DEATH Month 2 Day 22 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 3-22-1914		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY Clerk		11. BIRTHPLACE (State or foreign country) Maryland			
13. FATHER'S NAME Raymond K. Truitt				14. MOTHER'S MAIDEN NAME May Serman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. II		16. SOCIAL SECURITY NO. 214-10-8458		17. INFORMANT Mrs. R. King Truitt, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 10			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 2-27-66			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-25-1966		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery			
23. FUNERAL DIRECTOR'S SIGNATURE Hill Funeral Home		ADDRESS Salisbury, Maryland		24a. REC'D BY REGISTRAR DATE 2-23-66			
24b. REGISTRAR'S SIGNATURE				24c. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

03045

0032

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 30 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Parsons RD.,				d. STREET ADDRESS Parsons Rd.,			
3. NAME OF DECEASED (Type or print) First MAE Middle ELIZABETH Last TURNER				4. DATE OF DEATH Month 2 Day 20 Year 19 66			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 18, 1889	
				9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Stanford Culver				14. MOTHER'S MAIDEN NAME Elizabeth Ellen Nicholson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Mrs. Minnie C. Gordy, Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rupture of aortic aneurysm</i> DUE TO (b) <i>a.s.c. v.d.</i> DUE TO (c) <i>hypertension</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Earl L. Royer</i> EXAMINER'S NAME (Type) Dr. Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2-23-1966		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE Hill Funeral Home				ADDRESS Salisbury, Maryland		24a. REC'D BY REGISTRAR DATE 2-21-1966	
						24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03046

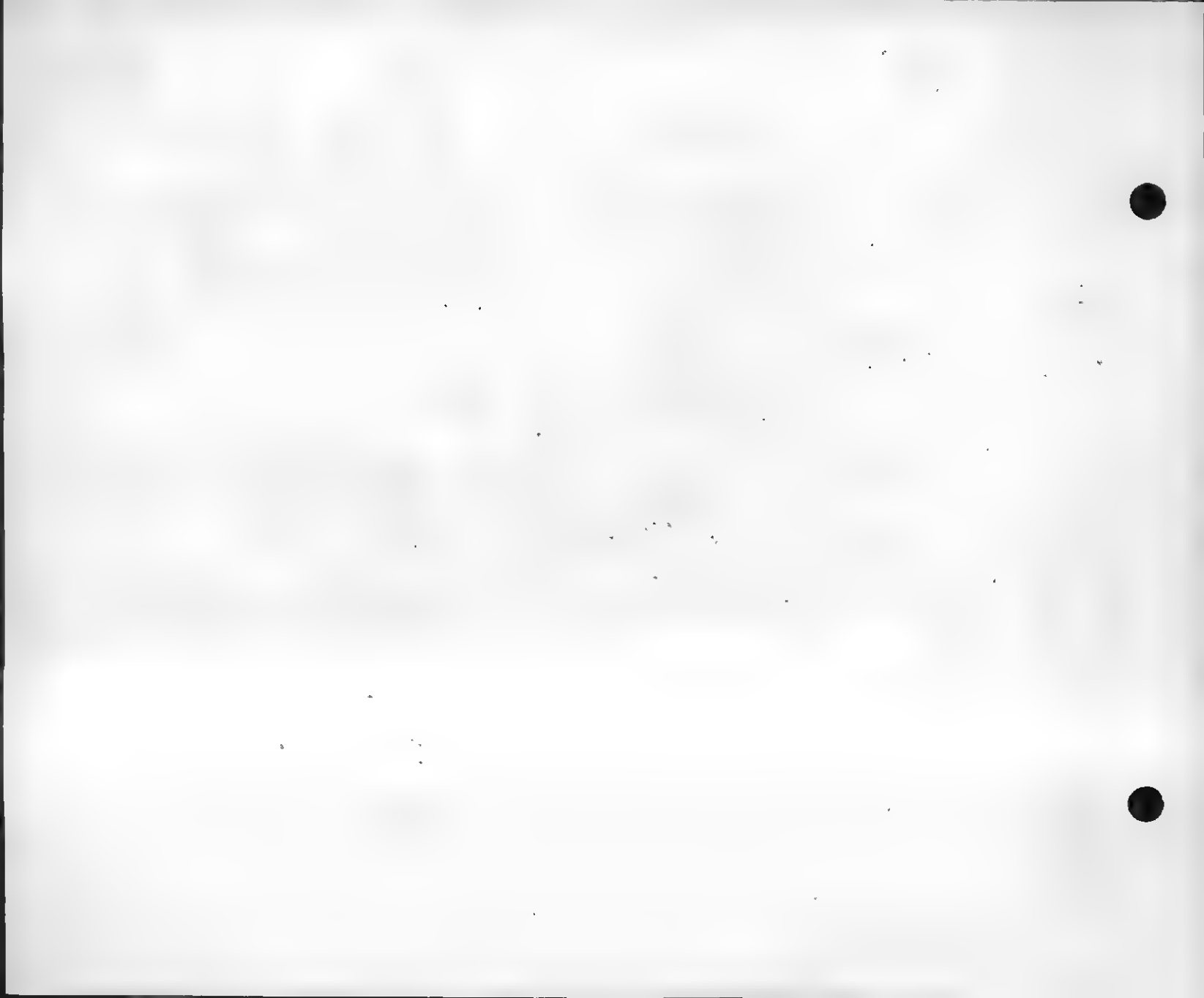
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15033

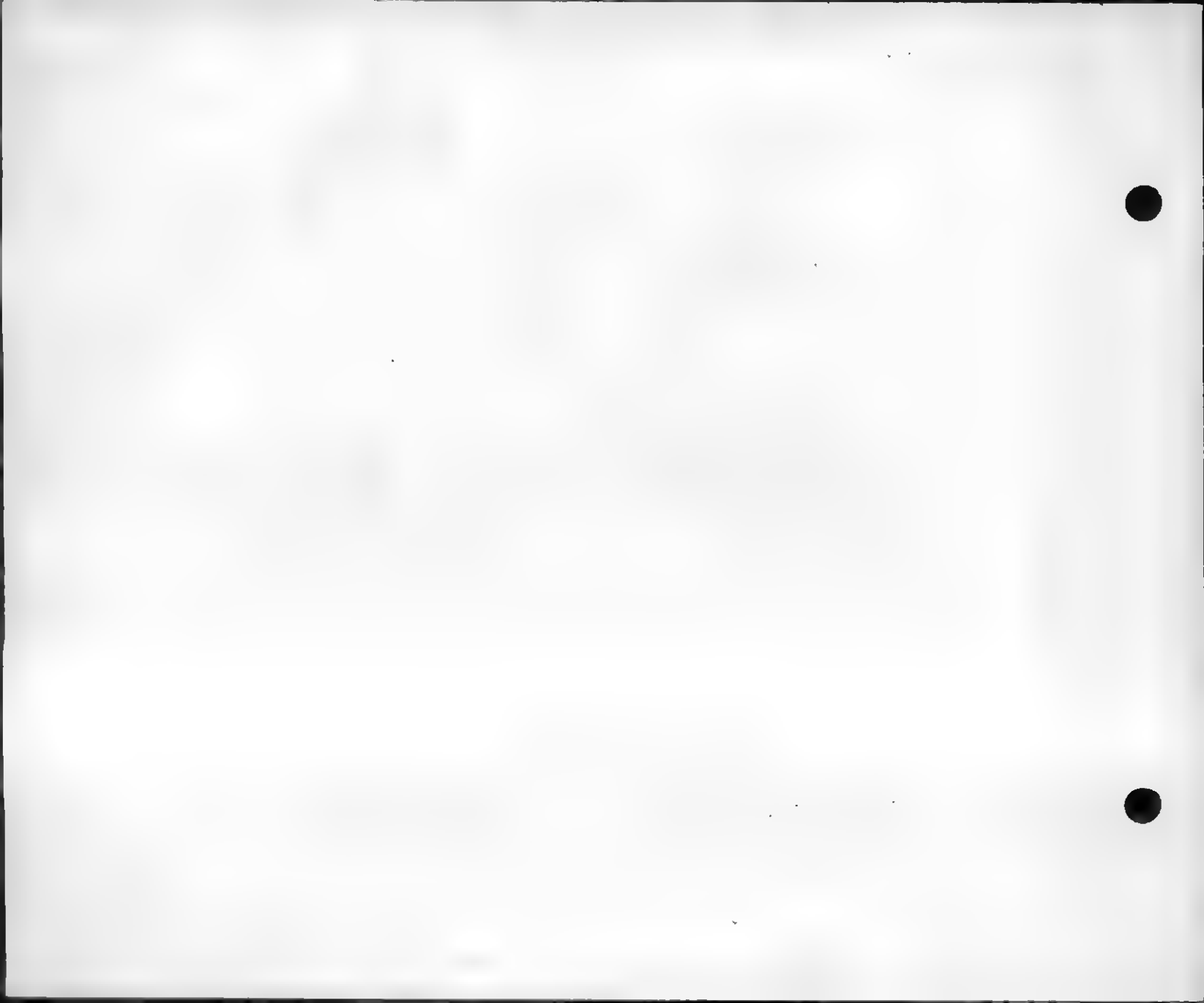
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>				d. STREET ADDRESS <u>821 Rogers St</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Jake Francis Walker Sr.</u>				4. DATE OF DEATH Month Day Year <u>February 9 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar 18 1895</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boat builder</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Somerset Co. Md</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>							
13. FATHER'S NAME <u>Dan E. Walker</u>				14. MOTHER'S MAIDEN NAME <u>Frances Miles</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <u>Mrs. Jennie Walker 821 Rogers St. Salisbury</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussion of brain from falling</u> DUE TO (b) <u>Coronary heart failure</u> DUE TO (c) <u>Arteriosclerotic deg. heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>163X</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 19 1964</u> to <u>Feb 7 1966</u> , that (I) (we) last saw the deceased alive on <u>2/8/66</u> 19 <u>66</u> , and that death occurred at <u>2:00</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Concepcion</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>All Saints Monie Venton</u>		23d. LOCATION (City, town or county) (State) <u>Md.</u>	
24. FUNERAL DIRECTOR <u>James J. Korman Prince Georges Anne Md</u>				25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Girdletree</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>H</u> Middle <u>WATERS</u> Last			4. DATE OF DEATH <u>FEBRUARY 10</u> 19 <u>66</u> Month Day Year						
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 7, 1887</u> 78 yrs.		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Canning Factory</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Girdletree, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Stevenson</u>				14. MOTHER'S MAIDEN NAME <u>Mariah Waters</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214 12 7298</u>		17. INFORMANT <u>John T. Waters, Girdletree, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerotic Heart Disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4200</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2/9</u> , 19 <u>66</u> to <u>2/10</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>2/10</u> , 19 <u>66</u> and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.									
22a. SIGNATURE <u>David J. [Signature]</u>					22b. DATE SIGNED			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>David J. [Signature]</u>					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2-16-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Coolspring Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Girdletree, Maryland</u>		
24. FUNERAL DIRECTOR <u>Thomas F. [Signature]</u>					25a. REC'D BY REGISTRAR <u>FEB 15 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02085

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN ID <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Dames Quarter</u> d. STREET ADDRESS <u>Main Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Lee White</u> First Middle Last 4. DATE OF DEATH <u>2-6-66</u> Month Day Year		5. SEX <u>M</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-24-51</u> 9. AGE (In years last birthday) <u>14</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Curtiss White</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Betty Roberts</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mrs. Betty Jones-Dames Quarter-Md</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage</u> <u>981X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gunshot wound of chest and abdomen</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Shotgun wound of abdomen.</u> 20c. TIME OF INJURY Month, Day, Year <u>2 P.m. 2-4-66</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) (County) (State) <u>Dames Quarter Somerset Id.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>40 hours</u> <u>40 hours</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u> EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u> 22. DATE SIGNED <u>2-7-66</u> Address (Street, city, town, or county) <u>109 Camden Ave. Salisbury, Md.</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-9-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Macedonia Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Dames Quarter MD</u>	
24. FUNERAL DIRECTOR <u>L J Webster</u> ADDRESS <u>Princess Anne MD</u>		25a. REC'D BY REGISTRAR <u>FEB 11 1966</u> DATE 25b. REGISTRAR'S SIGNATURE <u>J. J. Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

<p>1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u></p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u></p>		<p>c. LENGTH OF STAY IN 1b <u>23-1</u></p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u></p>		<p>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u></p>				<p>d. STREET ADDRESS <u>RFD</u></p>			
<p>3. NAME OF DECEASED (Type or print) First <u>MAME</u> Middle <u>JONES</u> Last <u>Whittington</u></p>			<p>4. DATE OF DEATH Month <u>FEB</u> Day <u>14</u> Year <u>1966</u></p>				
<p>5. SEX <u>Female</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>Nov. 1, 1877</u></p>	
<p>9. AGE (In years last birthday) <u>88</u> yrs.</p>		<p>IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>66</u> Min.</p>		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u></p>	
<p>11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN MD RFD</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u></p>		<p>13. FATHER'S NAME <u>ISAAC JONES</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>ELIZA ESHAM</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>215-38-1083</u></p>		<p>17. INFORMANT <u>Mrs. WILSIE MASSEY</u></p>		<p>Address <u>BERLIN MD RFD</u></p>	
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>443X</u> DUE TO (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u></u></p>						<p>INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.</p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that (I) (this hospital) attended the deceased from <u>2/14/1966</u> to <u>2/14/1966</u>, that (I) (we) last saw the deceased alive on <u>2/14/1966</u>, and that death occurred at <u>6:27</u> M, from the causes and on the date stated above.</p>							
<p>22a. SIGNATURE <u>[Signature]</u></p>				<p>22b. DATE SIGNED <u>2/14/66</u></p>			
<p>22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u></p>				<p>22d. ADDRESS <u>[Signature]</u></p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>23b. DATE THEREOF <u>2/17/66</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>EVER GREEN</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>BERLIN MD</u></p>	
<p>24. FUNERAL DIRECTOR <u>Anna R. Burbage</u></p>				<p>25a. REC'D BY REGISTRAR <u>[Signature]</u></p>			
<p>25b. REGISTRAR'S SIGNATURE <u>[Signature]</u></p>				<p>DATE <u>FEB 17 1966</u></p>			



TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film G374 3/7/66 MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
02050 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 02037									
1 PLACE OF DEATH a COUNTY Wicomico MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY St. Mary's				
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c LENGTH OF STAY IN b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) California				
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)					d STREET ADDRESS Rt. 2			e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Christopher Bruce Wilhelmy					4 DATE OF DEATH Month 2 Day 17 Year 66				
5 SEX M		6 COLOR OR RACE W		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH Oct. 23, 1935		9 AGE (In years, last birthday) yrs 30	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aviator		10b KIND OF BUSINESS OR INDUSTRY U. S. Navy		11 BIRTHPLACE (State or foreign country) Ohio			12 CITIZEN OF WHAT COUNTRY? USA		
13 FATHER'S NAME Christopher Bernard WILHELMY					14 MOTHER'S MAIDEN NAME Mary Elizabeth KANE				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv. ca.) Yes 1958-1966		16 SOCIAL SECURITY NO 460 64 1300		17. INFORMANT Address Official Navy Records					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple internal and external injuries, severe DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)									19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTENSAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Airplane crash.							
20c TIME OF INJURY Month, Day, Year 11 A.M. 2-17-66		20d INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury Wicomico Md.		20f (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Earl L. Royer		EXAMINER'S NAME (Type) Earl L. Royer, M.D.		22. DATE SIGNED 2-17-66		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 409 Camden Ave. Salisbury, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 2/21/66		23c NAME OF CEMETERY OR CREMATORY Arlington National		23d LOCATION (City or Town) (County) (State) Arlington, Virginia			
24 F. B. ROBINSON - Leonardtown, Md.				25a REC'D BY REGISTRAR FEB 24 1966		25b REGISTRAR'S SIGNATURE J. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03051

MARYLAND STATE DEPARTMENT OF HEALTH

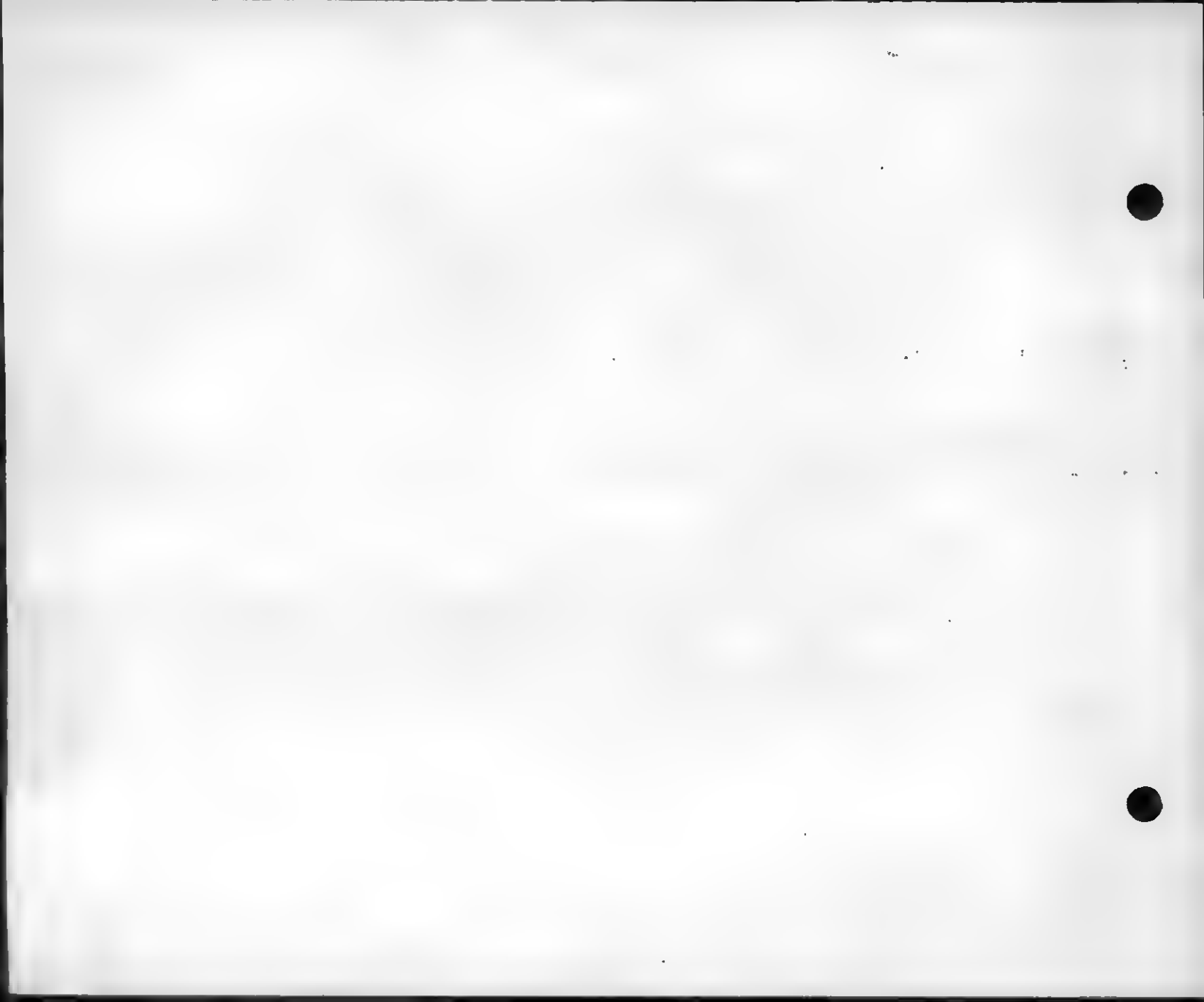
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12058

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALIBURY</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>466 Bank St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>WILLIAMS</u> Last <u>WILLIAMS</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>10</u> Year <u>1966</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1884</u>	9. AGE (In years last birthday) <u>81</u> yrs.	10. IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min.	11. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>		11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-05-2059</u>		17. INFORMANT <u>Virginia Williams - Salisbury, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Pulmonary embolism</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral arteriosclerosis</u> <u>Bladder diverticulum</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/4</u> , 19 <u>66</u> , to <u>2/12</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/4</u> , 19 <u>66</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard E. Hughes</u>				22b. DATE SIGNED <u>2/12/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Edgar L. Harton - New Church, Va.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-15-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Halls Hill</u>		23d. LOCATION (City, town or county) (State) <u>Pocomoke, Md.</u>	
24. FUNERAL DIRECTOR <u>Edgar L. Harton - New Church, Va.</u>				25a. REC'D BY REGISTRAR <u>FEB 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

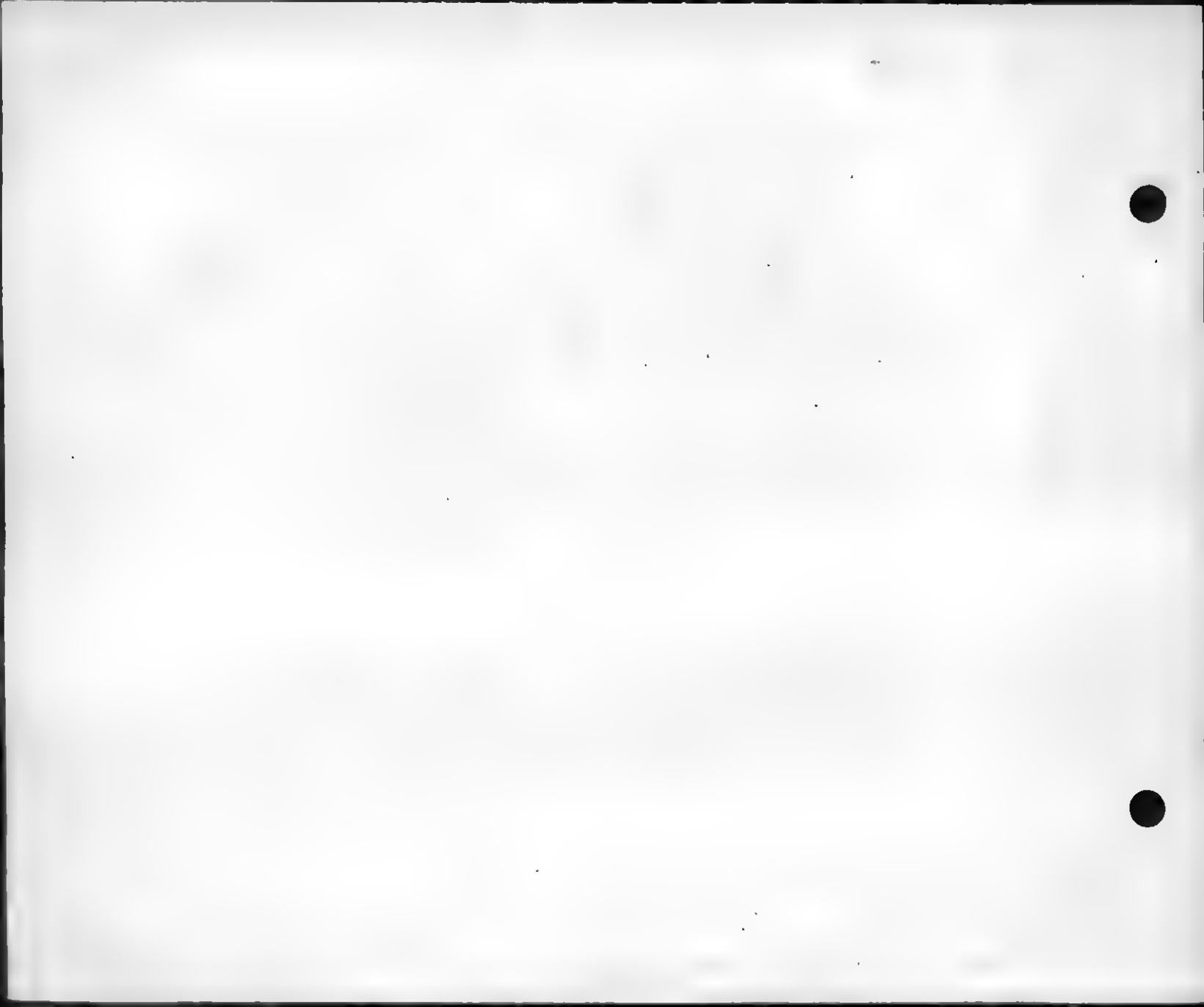
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bishop</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>rural</u>	
3. NAME OF DECEASED (Type or print) <u>Pete Williams</u>		4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 10, 1895</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>chicken farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Princeton, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Will Tindley</u>	
14. MOTHER'S MAIDEN NAME <u>Mattha Williams</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>215-26-4198</u>		17. INFORMANT <u>Augusta Foley Bishop, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 163X DUE TO (b) <u>Carcinoma of the lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 10, 1966</u> to <u>Feb 10, 1966</u> that (I) <u>last</u> saw the deceased alive on <u>Feb 10, 1966</u> , and that death occurred at <u>10:20 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Carl F. Berner</u>		22b. DATE SIGNED <u>2/12/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>CARL F. BERNER, M.D.</u>		22d. ADDRESS <u>Peninsula General Hospital</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burned</u>	23b. DATE THEREOF <u>2/14/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Showell Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Showell Md.</u>
24. FUNERAL DIRECTOR <u>Henry H. Watson</u>		25a. REC'D BY REGISTRAR <u>FEB 16 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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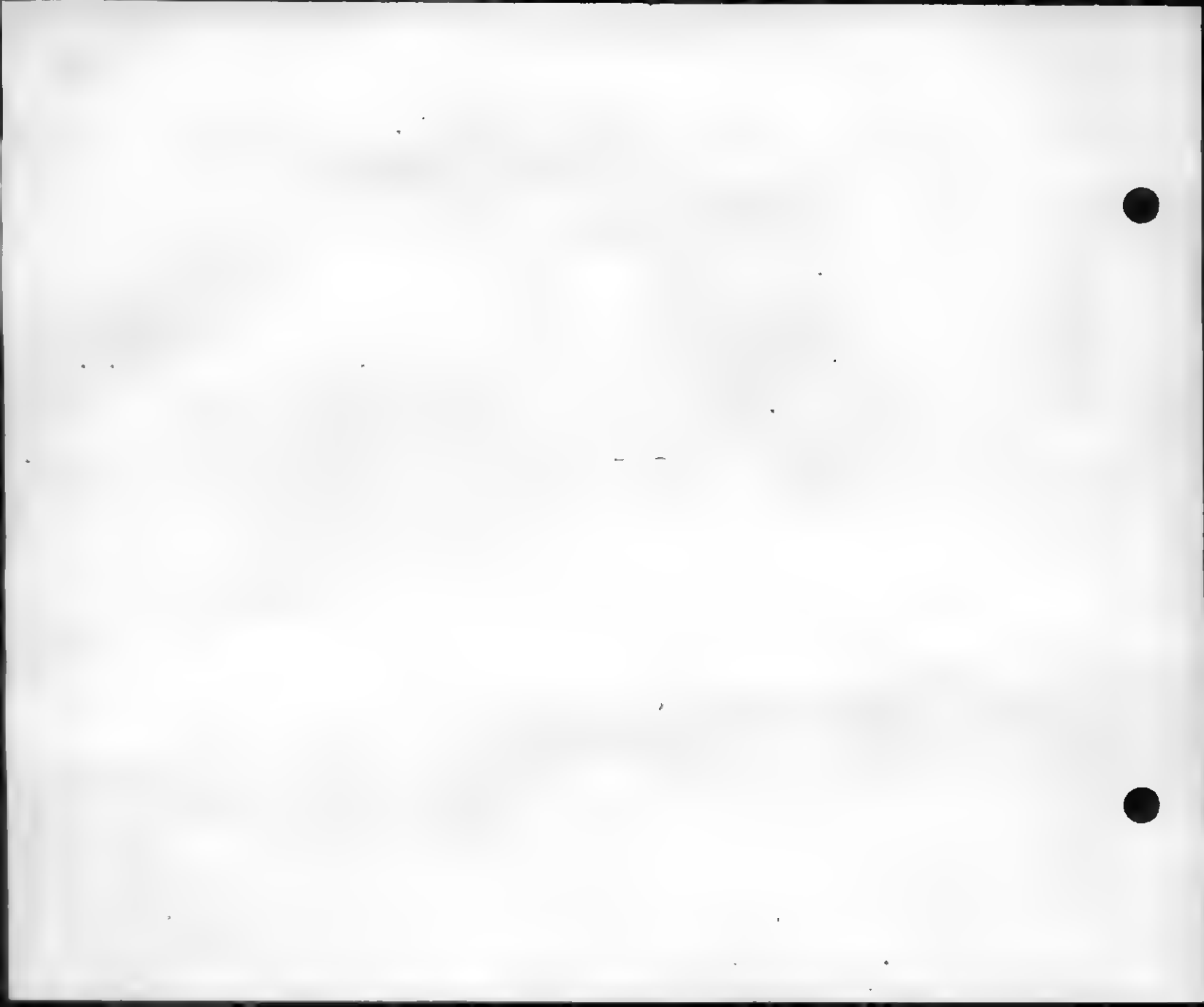
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02053
CERTIFICATE OF DEATH

000411

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				e. STREET ADDRESS <u>22-1</u>			
3. NAME OF DECEASED (Type or print) <u>IRA</u> First <u>F.</u> Middle <u>WILLING</u> Last				4. DATE OF DEATH <u>FEBRUARY 21</u> 19 <u>66</u> Month Day Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 4, 1886</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. BIRTHPLACE (County & State, or foreign country) <u>BIVALLE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED PAYMASTER</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>FRANKLIN A. WILLING</u>				14. MOTHER'S MAIDEN NAME <u>SUSAN DUNN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>220-16-9255A</u>		17. INFORMANT <u>MRS CHARLES LAVERY</u> Address <u>BALTIMORE, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pancreatitis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>21 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>nephritis with anemia</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/24/</u> , 19 <u>66</u> , to <u>2/21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/20/66</u> 19 <u>66</u> , and that death occurred at <u>8A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Raymond M. Gyn</u>				22b. DATE SIGNED <u>2/22/66</u>		22c. PHYSICIAN'S NAME (Type) <u> </u>	
22d. ADDRESS <u> </u>				22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/23/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BIVALLE CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>BIVALLE, MD.</u>	
24. FUNERAL DIRECTOR <u>LEVIN R. WILSON</u> ADDRESS <u>PRINCESS ANNE,</u>				25a. REC'D BY REGISTRAR <u>FEB 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



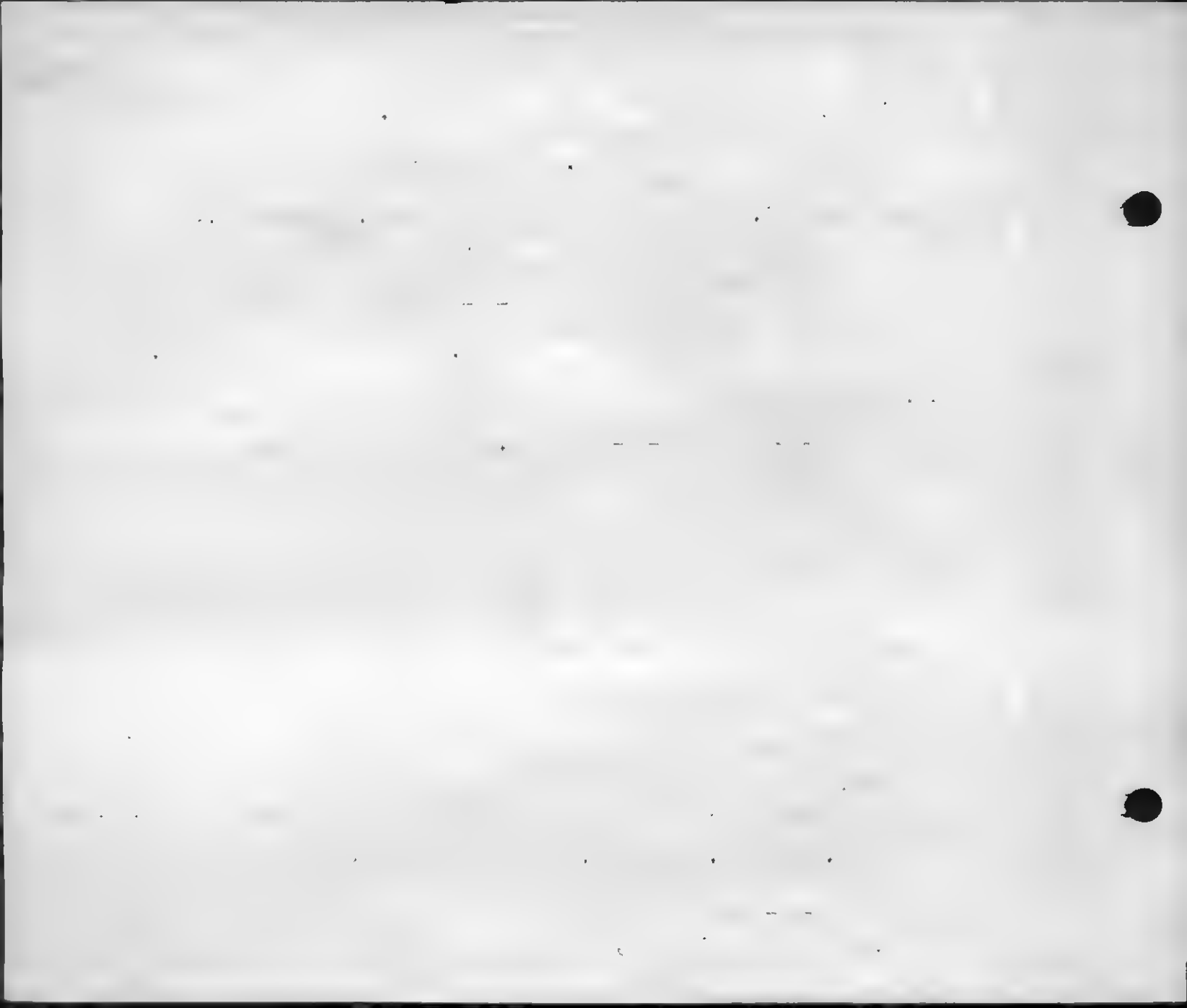
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

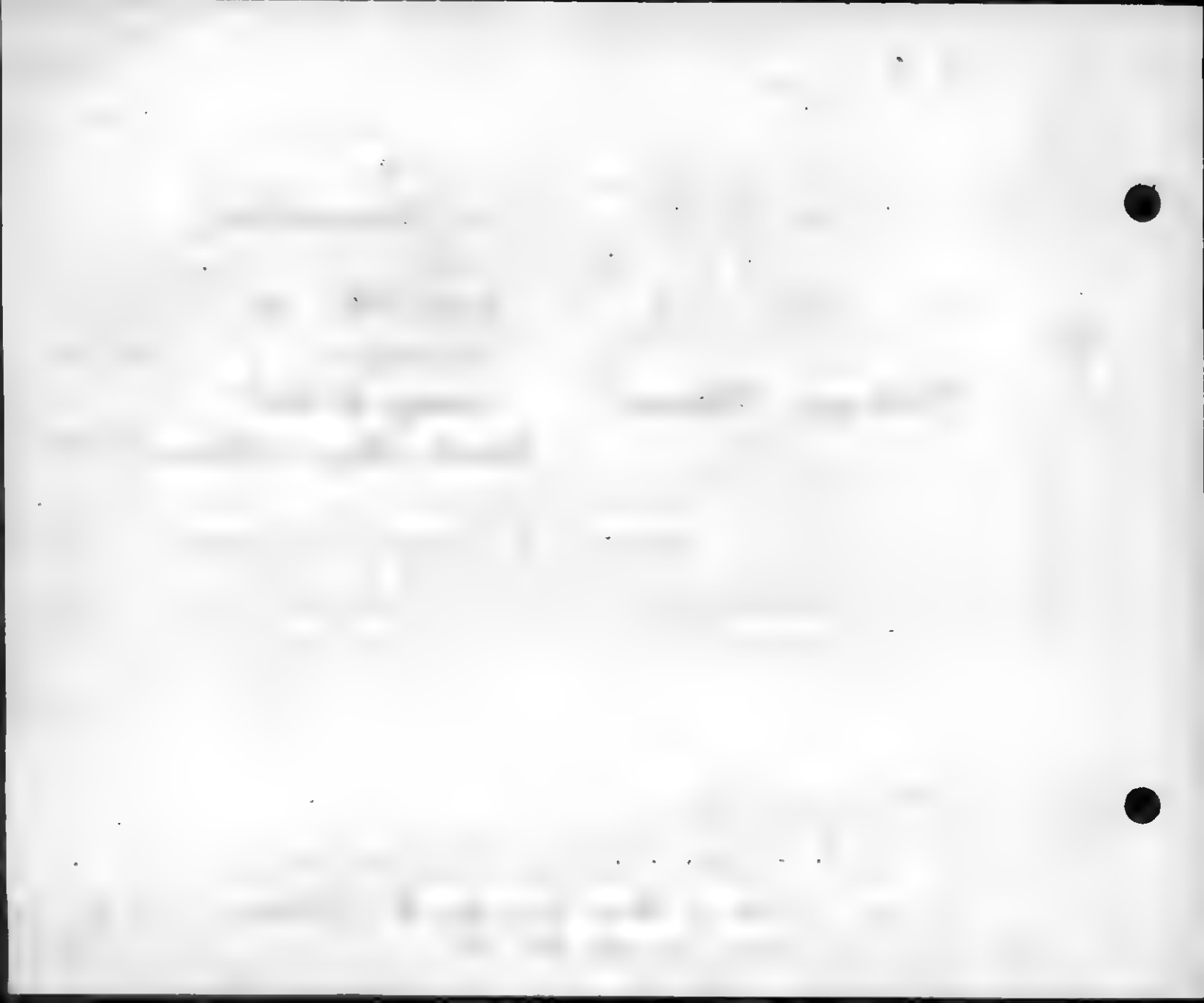
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN b 9 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Spring Hill Sani.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Va. b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Arlington d. STREET ADDRESS 1401 S. Buchanan St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CARRIE JOHNSTIN WILSON		4. DATE OF DEATH Last 2 Month 15 Year 1966			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-24-1893	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME U.S. Grant Johnstin		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 191-10-7490		17. INFORMANT Mrs. Myrtle McGuirk, Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Phenothiazine & sedatives - Verbena & Demerol DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 1955 to 2-16-1966 that (I) (we) last saw the deceased alive on 2-14-1966 , and that death occurred at 2-16-1966 M, from the causes and on the date stated above.					
22a. SIGNATURE Philip A. Insley Sr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-16-1966	
22c. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley Sr.		22d. ADDRESS Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-17-1966		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	
23d. LOCATION (City, town or county) Salisbury, Maryland		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE Hill Funeral Home		ADDRESS Salisbury, Maryland		25a. REC'D BY REGISTRAR FEB 18 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
03055 Item: 8, 7 Film 574 3/1/66											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 509 Rose Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Viola			First Viola Middle K. Last Wood			4. DATE OF DEATH Feb. 9 1966			Month Feb. Day 9 Year 1966		
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-22-1900		9. AGE (In years last birthday) 65 yrs.		10. FUNERAL 1 YEAR <input type="checkbox"/> UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Wicomico			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Niles						14. MOTHER'S MAIDEN NAME Mary Kuller					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Maudie Edgley - 2112 Delaware Ave. Salis			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4-01 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) Arteriosclerosis, general										INTERVAL BETWEEN ONSET AND DEATH 15 min. Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Old cerebral thrombosis											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11/2 1965 , to 2/9 1966 , that (I) (we) last saw the deceased alive on 2/9 1966 , and that death occurred at 2:20 A.M. M, from the causes and on the date stated above.											
22a. SIGNATURE L. V. Maldve, M. D.						22b. DATE SIGNED 2/9/66					
22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.						22d. ADDRESS Deer's Head Hospital; Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
Burial		2-17-66		Green Acres Mem. Pk.				Salisbury, Md.			
24. FUNERAL DIRECTOR Arvilla B. Jolley - Jersey Rd. Salis. Md.						25a. REC'D BY REGISTRAR Feb 16 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> d. STREET ADDRESS <u>R.F.D. 1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>George A. Wright</u>			4. DATE OF DEATH <u>February 13 1966</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 24, 1899</u> 9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>William Wright</u>			14. MOTHER'S MAIDEN NAME <u>Charlotte Purnell</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Della Wright R.F.D. 1 Snow Hill, Md.</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute Myocardial infarction</u> DUE TO (b) <u>arteriosclerotic Heart</u> DUE TO (c) <u>Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>congestive failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>few min</u>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 6</u> , 19 <u>66</u> to <u>Feb 13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 12</u> , 19 <u>66</u> and that death occurred at <u>10:30</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>David Rafat</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2-14-66</u>				
22c. PHYSICIAN'S NAME (Type) <u>DAVID RAFAT</u>			22d. ADDRESS <u>Snow Hill Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2-19-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Wesley Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Snow Hill, Md.</u>		
24. FUNERAL DIRECTOR <u>Samuel S. ...</u>			ADDRESS <u>New Church, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03057

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

03044

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SANBURY</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crisfield Md.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>LENINGUA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>114 S. 4TH ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CELESTA</u> Middle <u>L.</u> Last <u>YOUNG</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>25</u> Year <u>1966</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 16, 1927</u>	9. AGE (in years last birthday) <u>38</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CHESTER PA.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEA FOOD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Ralph Milbourne</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Smith</u>			
15. WAS DEPOSED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Joseph Young</u> Address <u>Crisfield Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PERITONITIS</u> <u>1531</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>CARCINOMA - HEPATIC FLUORE-CAN.</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>25 Feb 1966</u> , 19 <u>66</u> to <u>25 Feb 1966</u> , that (I) (we) last saw the deceased alive on <u>25 Feb 1966</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Ed. Gray Reas</u>				22b. DATE SIGNED <u>26 Feb 66</u>		22c. PHYSICIAN'S NAME (Type) <u>Anthony E. Lane</u>	
22a. SIGNATURE <u>Ed. Gray Reas</u>		22b. DATE SIGNED <u>26 Feb 66</u>		22c. PHYSICIAN'S NAME (Type) <u>Anthony E. Lane</u>		22d. ADDRESS <u>Crisfield Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/1/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u>		23d. LOCATION (City, town or county) (State) <u>Crisfield Md.</u>	
24. FUNERAL DIRECTOR <u>Anthony E. Lane</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 3 1966</u>	

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